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DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Subacute Alcoholism and Substance Abuse Treatment Services

2) Code Citation: 77 Ill. Adm. Code 2090

3)

Section Numbers:	Proposed Action:
2090.20	Amended
2090.40	Amended
2090.70	Amended

4) Statutory Authority: Section 5-10 of the Illinois Alcoholism and Other Drug Dependency Act, 20 ILCS 301/5-10.

5) A Complete Description of the Subjects and Issues Involved: The rule is being amended to assure the most cost effective use of government dollars for reimbursing subacute substance abuse treatment services for eligible clients and to assure that core substance abuse services reimbursable by the State continue to be available to the greatest number of persons in need of the services.

It places reasonable benefit limits on reimbursable services and deletes some services from Medicaid reimbursement. Adult residential rehabilitation is being deleted but adolescent residential rehabilitation will continue to be reimbursed. Detoxification services are being deleted. Adult and adolescent day treatment and intensive outpatient treatment will continue to be reimbursed, but only for drug-free treatment services, and ancillary methadone services are deleted.

The benefit limits are as follows: (1) outpatient drug-free services - 40 hours per year for an adolescent client and 25 hours per year for an adult client; (2) intensive outpatient - 75 hours per year; (3) adolescent residential and day treatment - 40 days per years, alone or in combination with each other; (4) adult day treatment - 30 days per year.

6) Will the proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this rulemaking contain incorporation by reference? No

9) Are there any other amendments pending on this Part? Yes

10) Statement of Statewide Policy Objectives: A Statement of Statewide Policy Objectives is not necessary.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Interested persons should address their written comments concerning these rules within 45 days to:

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Nancy J. Bennett, General Counsel
Department of Alcoholism and Substance Abuse
James R. Thompson Center
100 W. Randolph Street, Suite 5-600
Chicago, IL 60601
(312) 814-6329

The proposed changes will also be posted in substance abuse treatment facilities and local Public Aid offices (except that in Cook County they shall be posted at the Public Aid Office at 310 South Michigan Ave., Chicago).

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses affected: For profit and not-for-profit individuals, corporations, or other entities that perform Medicaid reimbursable substance abuse treatment services.

B) Reporting, bookkeeping or other procedures required for compliance: No new reporting is required.

13) Types of professional skills necessary for compliance: No new or additional professional skills are necessary.

14) State reason(s) for this rulemaking if it was not included in either of the two (2) most recent regulatory agendas: This was included in the January 1995 agenda.

The full text of the Proposed Rule begins on the following page of this issue of the Illinois Register:

DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

NOTICE OF PROPOSED AMENDMENTS

TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE
SUBCHAPTER g: MEDICAID PROGRAM STANDARDS

PART 2090
SUBACUTE ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT SERVICES

Section
2090.10 Purpose
2090.20 Definitions
2090.30 Medicaid Enrollment Licensure
2090.35 General Requirements
2090.40 Reimbursable Services
2090.50 Utilization Review
2090.60 Recordkeeping
2090.70 Rate Setting
2090.80 Rate Appeals
2090.90 Application and Certification Process
2090.100 Recertification and Inspection
2090.110 Sanctions for Non-Compliance

AUTHORITY: Implementing and authorized by Section 5-10 of the Alcoholism and Other Drug Dependency Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 6354-1) [20 ILCS 301/5-10].

SOURCE: Adopted at 11 Ill. Reg. 2236, effective January 14, 1987; emergency amendments at 12 Ill. Reg. 11273, effective June 30, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 20061, effective November 26, 1988; emergency amendments at 15 Ill. Reg. 10222, effective June 25, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 16662, effective November 1, 1991; amended at 16 Ill. Reg. 11807, effective July 14, 1992; amended at 18 Ill. Reg. 14223, effective September 2, 1994; amended at 19 Ill. Reg. _____, effective _____.

Section 2090.20 Definitions

The following definitions shall apply to this Part:

"Adolescent": A person who has reached his/her twelfth birthday but has not yet reached his/her eighteenth birthday.

"Clinical Supervision": The review of treatment cases and the use of other supervisory techniques for the purposes of assuring that a client's clinical needs are met.

"Department": The Illinois Department of Alcoholism and Substance Abuse.

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"Drug-free treatment": Treatment service which does not include the use of methadone, LAAM or other drugs used for substance abuse treatment.

"Follow-up": Routine scheduled or unscheduled provider contact with a former client that occurs after the client has been discharged, has been previously specified in the client's treatment and discharge plan, and occurs for a period of time and at least at specified intervals. Follow-up is for the purpose of offering the individual continuing assistance as necessary to maintain and improve upon the clinical goals achieved during treatment.

"Individualized Treatment Plan": The written plan which identifies the care and treatment to be provided to the client based upon documented assessment of his/her individual problems and needs as well as strengths and resources.

"Physician": A person who is licensed to practice medicine in all its branches under the Medical Practice Act of 1987 (Ill. Rev. Stat. 1991, ch. 111, par. 4400-1 et seq.) [225 ILCS 60].

"Provider": Any public or private agency, organization, or institution, or unit of state or local government or other legal entity licensed to deliver alcoholism or other drug abuse services according to the requirements specified in Section 2090.30 and enrolled to provide treatment services under the Illinois Medical Assistance Program.

"Psychiatrist": A person licensed to practice medicine in all its branches under the Medical Practice Act of 1987 (Ill. Rev. Stat. 1991, ch. 111, par 4400-1 et seq.) [225 ILCS 60] and who meets the requirements of Section 1-121 of the Mental Health and Developmental Disabilities Code (Ill. Rev. Stat. 1991, ch. 91 1/2, par. 1-121) [405 ILCS 5/1-121].

"Qualified Alcoholism and Other Drug Treatment Professional": A person who has a minimum of 2000 hours of paid formal work experience in the field of alcoholism/substance and/or other drug abuse under clinical supervision including at least 1500 documented hours of direct client service and at least 40 clock hours of formal training in the field of alcoholism/substance and or other drug abuse. The supervised and documented direct client service hours shall include the following alcoholism/substance and/or other drug abuse client services and treatment activities: screening; assessment and evaluation; treatment planning; intervention; referral activities; client education; case management and consultation; clinical recordkeeping; and recovery support. Direct treatment activities shall include clinically supervised experience working with

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individuals, groups, and families. A qualified alcoholism and other drug treatment professional may also be a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987; a person registered as a psychologist pursuant to the Clinical Psychology Practice Act (Ill. Rev. Stat. 1991, ch. 111, par. 5351) [225 ILCS 15]; a person licensed as a social worker or licensed clinical social worker pursuant to the Clinical Social Work and Social Work Practice Act (Ill. Rev. Stat. 1991, ch. 111, par. 6351) [225 ILCS 20]; or a person holding a masters or higher level degree in counseling; or a person certified by the Illinois Alcoholism and Other Drug Abuse Professional Certification Association (IAODAPCA) as a "counselor," "reciprocal," "supervisor" or "master" in accordance with Certified Alcohol and Other Drug Abuse Counselor Classifications Eligibility Standards for Certification, January 7, 1992 (available from the IAODAPCA at 1305 Wabash Avenue, Suite L, Springfield, Illinois). ~~In a detoxification service, a qualified treatment professional may also be a person licensed as a registered nurse pursuant to Section 3(k) of the Illinois Nursing Act of 1987 (Ill. Rev. Stat. 1991, ch. 111, par. 3503(k)) (425 ILCS 55/3(k)); a licensed practical nurse pursuant to Section 3(i) of the Illinois Nursing Act of 1987 (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 3503(i)) (425 ILCS 55/3(i)); or a person certified as an emergency medical technician pursuant to Section 4.12 of the Emergency Medical Services (EMS) Systems Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 5504.12) (210 ILCS 50/4.12); who (except for the registered nurse) has completed at least 40 clock hours of formal training in the field of alcoholism or other drug abuse.~~ In the case of a licensee under the Hospital Licensing Requirements rules, a person determined to be appropriate to deliver the clinical services provided, pursuant to by-laws, rules and regulations approved by the hospital Governing Board under 77 Ill. Adm. Code 250, Subpart C regarding "medical staff" and Section 250.2850 regarding "medical and professional staff."

"Qualified Alcoholism and Other Drug Treatment Supervisor": A person who in addition to meeting the requirements for a qualified alcoholism and other drug treatment professional, has at least an additional 4,000 hours paid work experience in the field of alcoholism/substance and/or other drug abuse and has at least 10 clock hours in formal training in the philosophy and techniques of supervision.

"Recommended by a Physician": The physician formulation of, approval of, or involvement in each client's treatment plan within 14 (calendar) days from the date of initial services. The physician shall establish or approve a diagnosis which, to be reimbursed as a Medicaid service under this Section, must be a diagnosis of alcoholism and/or other drug abuse. Evidence of the physician's supervision must be documented by the physician's signed and dated approval of the treatment plan or signed and notation indicating concurrence with the

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plan of treatment in client's record. The physician must provide a handwritten signature. The provider shall not use a signature stamp.

"Subacute": The level of care necessary to effectively treat an alcohol and/or other drug abuser's dependency on a chemical, without the more intensive measures designed to treat primary medical conditions in an acute care setting (e.g., inpatient hospitalization). Subacute care may be delivered in a facility licensed under the rules for Licensure of Alcoholism and Substance Abuse Treatment, Intervention and Research Programs (77 Ill. Adm. Code 2058) or in a hospital, either of which is certified according to Section 2090.90 for purposes of Medicaid reimbursed alcoholism and/or other drug abuse services.

"Treatment Protocol": Written policies and procedures which describe the client services delivered by the provider. These policies and procedures must be approved and signed by a physician.

~~"Under age 21" means one who is admitted to treatment services prior to his/her 21st birthday up until he/she no longer requires services or reaches the age of 22, whichever comes first.~~

"Under the direction of a physician": Treatment services done under the direct supervision of a physician who is on staff and continuously directing the provision of care.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 2090.40 Reimbursable Services

a) Outpatient Services

1) The provision of face-to-face diagnostic and individual, group, or family drug-free treatment on a scheduled or unscheduled basis to an individual who in the clinical judgment of a qualified alcoholism and other drug treatment professional is experiencing a problem with alcohol or other drugs (e.g., family, social, financial, employment, educational, and/or legal). Services are delivered in a Medicaid enrolled non-residential subacute setting. However, outpatient services may be provided in a recipient's place of residence or other off-site location when required because of illness, disability, infirmity, or problems of accessing care at a certified site, as documented in the recipient's individualized treatment plan. This service is designed to reduce or eliminate an individual's intake of alcohol and/or other drugs.

2) Scope

Outpatient treatment services must be delivered in accordance

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with an individualized treatment plan recommended by a physician. Services shall include, but are not limited to assessment, diagnosis and subsequent individual, group, or family counseling, case coordination, aftercare, and follow up.

3) Admission Criteria
To be admitted for outpatient treatment, an individual must be experiencing problems as a result of using alcohol or other drugs and, in the clinical judgment of a qualified treatment professional, must not be actively experiencing psychotic manifestations, or other severe mental or physical illness, which require immediate acute medical or psychiatric care. In addition, the individual must not be intoxicated, incapacitated due to the effects of alcohol or other substances, or in withdrawal. An individual's physical and emotional condition must allow them to function in their usual non-residential setting.

4) Staffing Qualifications
A) Outpatient services must be delivered by qualified alcoholism and other drug treatment professionals.
B) Each qualified alcoholism and other drug treatment professional providing treatment services must receive a minimum of four hours per month of direct clinical supervision delivered in no less than 2 sessions, by a qualified alcoholism and other drug treatment supervisor.

5) Reimbursement
Outpatient treatment services delivered to Aid to the Aged, Blind, and Disabled (AABD), Aid to Families with Dependent Children (AFDC), Medical Assistance, No Grant (MANG), Refugee Repatriate Program (RRP) recipients, Title XIX eligible Department of Children and Family Services (DCFS) wards, and persons under the age of eighteen who would qualify for AFDC but do not qualify as dependent children pursuant to 89 Ill. Adm. Code 140.7, are Medicaid-reimbursable via the prospective rates in effect as of the date of service (89 Ill. Adm. Code 148.370). Medicaid claims are submitted to the Department and shall meet the requirements of IDPA rules pursuant to 89 Ill. Adm. Code 148.340-148.370 for alcoholism and substance abuse treatment providers. The billable outpatient unit of service is a client hour defined as face-to-face counseling with a diagnosed client in an individual, group, or family setting. Reimbursement shall occur by a fee-for-service mechanism, using one client hour as the base unit of service, billable to the nearest quarter-hour. No more than two client hours shall be reimbursed for any client during a 24 hour period, except that the maximum number of hours may be extended by the provider to three during a 24 hour period on an individual basis when circumstances exist which limit accessibility to treatment services. These circumstances, such as significant travel distances, must be documented in the individualized treatment plan. In instances where the provider

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has extended the client hours beyond two per 24 hour period, no more than two of those client hours may be reimbursed for group treatment. No more than 40 hours may be reimbursed for an eligible adolescent client per benefit year, and no more than 25 hours may be reimbursed for an eligible adult client per benefit year.

b) Intensive Outpatient Treatment

1) Definition
The provision of diagnostic services and individual or group drug-free treatment on a scheduled-only outpatient basis in a Medicaid enrolled subacute setting. This service is designed to reduce or eliminate, through a controlled milieu, an individual's intake of alcohol and/or other substances.

2) Scope
Intensive outpatient treatment services must be delivered in accordance with an individualized treatment plan recommended by a physician. Services shall include, but are not limited to assessment, evaluation, diagnosis, and subsequent individualized, group, or family counseling, education, case coordination, aftercare and follow-up. Intensive outpatient treatment is a structured program offered a minimum of two days or evenings per week (not exceeding 4 hours per day) with a range of at least 6 hours to a maximum of 20 hours of treatment activities by professional staff per client per week.

3) Admission Criteria
Individuals admitted to intensive outpatient treatment must, in the clinical judgment of a qualified alcoholism and other drug treatment professional, be experiencing problems related to their addictive or abusive use of alcohol and/or other drugs which requires a level of care exceeding that available in outpatient treatment. Individuals experiencing active psychotic manifestations, or other severe mental or physical illness which requires immediate acute medical or psychiatric care, should not be admitted to intensive outpatient treatment. In addition, the individual shall not be intoxicated, incapacitated due to the effects of alcohol or other drugs, or in withdrawal.

4) Staffing Qualifications
At least one qualified alcoholism and other drug treatment professional must deliver at least 50% of direct client treatment services during each treatment session. Additional services may be delivered by specialty staff, for example, vocational counselors or activity therapists.

5) Reimbursement
Intensive outpatient treatment services provided to AABD, AFDC, MANG, and RRP recipients, Title XIX eligible DCFS wards, and persons under the age of eighteen who would qualify for AFDC but do not qualify as dependent children pursuant to 89 Ill. Adm. Code 140.7, are Medicaid reimbursable via the prospective rates

in effect as of the date of service (89 Ill. Adm. Code 148.370). Medicaid claims are submitted to the Department, and shall meet the requirements of IDPA rules pursuant to 89 Ill. Adm. Code 148.340 through 148.370 for alcoholism and substance abuse treatment providers. Reimbursement shall occur by a fee-for-service mechanism, using one client session of a minimum of three hours as the base unit of service. No more than one client session shall be reimbursed per 24 hour period. Services for clients enrolled in intensive outpatient treatment shall not be reimbursed under the provisions for outpatient services. No more than 75 hours shall be reimbursed for an eligible client per benefit year.

c) Adolescent Residential Rehabilitation

1) Definition

The provision of diagnostic services and individual or group drug-free treatment services for adolescents on a scheduled-only residential basis in a Medicaid enrolled hospital subacute setting; or to ~~individuals~~ adolescents under age 18 ~~21~~ in a psychiatric facility or an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), 875 North Michigan Avenue, Chicago, Illinois. This service is designed to reduce or eliminate, through a controlled milieu, an adolescent's ~~individual's~~ intake of alcohol and/or other drugs.

2) Scope

Residential rehabilitation must be delivered in accordance with an individualized treatment plan recommended by a physician if in a hospital setting, and under the direction of a physician if in a psychiatric facility. Services must include, but are not limited to assessment, evaluation, diagnosis, and subsequent individual, group, or family counseling, education, case coordination, aftercare and follow-up. Residential rehabilitation is a structured residential program offered seven days per week and includes a minimum of 25 hours of treatment activities per client per week.

3) Admission Criteria

Individuals admitted to residential rehabilitation must, in the clinical judgment of a qualified alcoholism and other drug treatment professional, be experiencing problems related to their addictive or abusive use of alcohol and other drugs which requires a level of care exceeding that available in outpatient and intensive outpatient treatment. Individuals experiencing active psychotic manifestations, or other severe mental or physical illness which requires immediate acute medical or psychiatric care, should not be admitted to residential rehabilitation. In addition, the individual shall not be intoxicated, incapacitated due to the effects of alcohol or other drugs, or in withdrawal.

4) Staffing Qualification

At least one qualified alcoholism and other drug treatment professional must deliver at least 50% of direct client treatment services during each treatment session. Additional services may be delivered by specialty staff, for example, vocational counselors or activity therapists.

5) Reimbursement

Residential rehabilitation services provided to adolescent AABD, AFDC, MANG, and RRP recipients, Title XIX eligible DCFS wards, and persons under the age of eighteen who would qualify for AFDC but do not qualify as dependent children pursuant to 89 Ill. Adm. Code 140.7, are Medicaid reimbursable via the prospective rates in effect as of the date of service (89 Ill. Adm. Code 148.370). Medicaid claims are submitted to the Department and shall meet the requirements of IDPA rules pursuant to 89 Ill. Adm. Code 148.340 through 148.370 for alcoholism and substance abuse treatment providers. Reimbursement shall occur on a per diem basis. Services for clients enrolled in a residential rehabilitation program with over 16 beds shall not be reimbursed under the provisions for outpatient, or intensive outpatient ~~or detoxification~~ services. No more than 40 days shall be reimbursed in each benefit year for an eligible client for adolescent residential rehabilitation alone or in combination with day treatment.

~~d) Detoxification~~

~~1) Definition~~

~~The provision of immediate physiological stabilization and diagnostic and short-term treatment on a non-scheduled basis to an individual who is intoxicated or experiencing withdrawal from the ingestion of alcohol and/or other drugs, and whose physical and emotional condition does not require the intensity of an acute care setting, but does require intensive monitoring and observation. Detoxification is care provided in a Medicaid enrolled hospital subacute setting, or to individuals under age 21 by a Medicaid enrolled psychiatric facility or an inpatient program in a psychiatric facility, either of which is accredited by JCAHO, to an individual whose physical and emotional condition requires ongoing monitoring and observation, as well as more intensive assessment and treatment counseling, and is intended to lead to further treatment as necessary. This service is provided in a highly controlled and supportive residential subacute environment.~~

~~2) Scope~~

~~Detoxification services shall be provided in accordance with a treatment protocol approved and signed by a physician if in a hospital, and under the direction of a physician if in a psychiatric facility. Services shall include but are not limited to assessment, evaluation, diagnosis, determination of need for~~

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more--specialized--medical--care,--rest--under-close-observation, individual-counseling,-case-coordination-and-subsequent-referral, room-and-board,-meals,-and-supervision-by-staff.

3) Admission Criteria
To be admitted for detoxification, an individual must be intoxicated or incapacitated by alcohol and/or other drugs, and/or must be experiencing alcohol and/or other drug withdrawal. However, an individual must not be comatose and must not be actively experiencing psychotic manifestations or other severe mental or physical illness which requires immediate acute medical or psychiatric care.

4) Staffing Qualifications
At least two staff members one of whom is a qualified alcoholism and other drug treatment professionals, are to be on duty at all times.

5) Reimbursement
Detoxification services provided to AABD, APDC, MANG, and RRP recipients, Title XIX eligible DCFS wards, and persons under the age of eighteen who would qualify for APDC but do not qualify as dependent children pursuant to 89 Ill. Adm. Code 140.7, are Medicaid reimbursable via prospective rates in effect as of the date of service (89 Ill. Adm. Code 140.370). Medicaid claims are submitted to the Department and shall meet the requirements of IDPA rules pursuant to 89 Ill. Adm. Code 140.340 through 140.370 for alcoholism and substance abuse treatment providers. Reimbursement for detoxification services shall occur on a per diem basis. However, admissions less than 12 hours in length shall be reimbursed at a per episode rate. No more than one client episode shall be reimbursed per 24 hour period.

de) Day Treatment Services

1) Definition
The provision of drug-free treatment services as defined in subsection (c)(1) above, except that the services shall be provided by a program licensed pursuant to 77 Ill. Adm. Code 2058.372-376 and certified hereunder as having 16 beds or less and may be provided to adults in addition to adolescents. To be certified as having 16 beds or less a program must either be a free-standing program of 16 or fewer beds or, within a larger facility, be a unit of 16 beds or less and:

A) be separately certified and licensed;

B) be physically separate from other certified and licensed programs (for example, be separated by floors, wings, or other building sections);

C) provide a level of care significantly different in clinical content from other certified and licensed programs (for example, adult versus adolescent care, women versus men, hearing impaired versus non-impaired, etc.);

D) have a separate cost center;

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E) have separate staffing; and

F) have separate operating policies and procedures.

2) Scope
The scope of services is the same as set forth in subsection (d)(2) excluding room and board, meals, night supervision of dormitory areas and other domiciliary support services.

3) Admission Criteria
Admission criteria shall be the same as those set forth in subsection (c)(3) above.

4) Reimbursement
Day treatment services shall be reimbursed at an all-inclusive per diem rate as set forth in Section 2090.70(c)(5), available upon certification of the facility and approval of the Illinois Public Aid State Plan provisions for day treatment by the Health Care Financing Authority (HCFA). No more than 30 days shall be reimbursed per benefit year for an eligible adult client and no more than 40 days shall be reimbursed per benefit year for an eligible adolescent client for day treatment alone or in combination with adolescent residential rehabilitation.

f) Day Detoxification Services

1) Definition
The provision of detoxification services as defined in subsection (d)(1) above, except that the services shall be provided by a program licensed pursuant to 77 Ill. Adm. Code 2058.300 304 and certified hereunder as having 16 beds or less.

2) Scope
The scope of services is the same as set forth in subsection (d)(2) excluding room and board, meals, night supervision of dormitory areas and other domiciliary support services.

3) Admission Criteria
Admission criteria shall be the same as those set forth in subsection (d)(3) above.

4) Staffing Qualifications
Staffing qualifications shall be the same as set forth in subsection (d)(4) above.

5) Reimbursement
Day detoxification services shall be reimbursed at an all inclusive per diem rate as set forth in Section 2090.70(c)(6), available upon certification of the facility and approval of the Illinois Public Aid State Plan provisions for day treatment by the Health Care Financing Authority (HCFA).

eg) Ancillary Psychiatric Diagnostic Services

1) Ancillary psychiatric diagnostic services are limited psychiatric evaluations to determine whether the individual's primary condition is attributable to the effects of alcohol or drugs or to a diagnosed psychiatric or psychological disorder. Such an evaluation shall determine the individual's primary condition and recommend appropriate treatment services.

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2) Psychiatric evaluations reimbursable through Medicaid are limited to a psychiatric evaluation/examination of a client and the exchange of information with the primary physician and other informants such as nurses, counseling staff, or family members and the preparation of a report including psychiatric history, mental status, and diagnosis. This service shall be performed by a psychiatrist.

3) Psychiatric evaluations may be delivered to individuals admitted to outpatient, residential rehabilitation, intensive outpatient, or detoxification services where the need for such services is documented in the client's individualized treatment plan. Documentation of all such services shall be maintained in the client record.

4) Ancillary diagnostic services delivered to AABD, AFDC, MANG, and RRP recipients, Title XIX eligible DCFS wards, and persons under the age of eighteen who would qualify for AFDC but do not qualify as dependent children pursuant to 89 Ill. Adm. Code 140.7, are Medicaid-reimbursable on a per-encounter basis at the prevailing rate as established by IDPA pursuant to 89 Ill. Adm. Code 140.400.

~~n) Ancillary Methadone Services~~

~~Ancillary methadone services reimbursable through Medicaid are limited to initial and ongoing face to face medical examinations which are medically necessary; methadone delivery and monitoring; and collection; processing and related toxicology testing of client urine specimens. In order to be reimbursable these services must be delivered to Medicaid recipients who are served in an enrolled Methadone Treatment program. Reimbursement is available from the effective date of approval by HCFA of the Illinois Public Aid State Plan provisions regarding ancillary methadone services. Such services must be rendered in accordance with the standards established in 21 CFR 291.505 (1991) and 77 Ill. Adm. Code 2058.~~

~~1) Physician services must be performed by a physician who holds a current and unencumbered license to practice medicine in Illinois, who is enrolled in good standing in the Illinois Medicaid program and is an individual practitioner employed by or under contract with the participating methadone program.~~

~~A) The initial Comprehensive Medical Examination must be done in accordance with the standards set forth in 77 Ill. Adm. Code 2058.330 and 21 CFR 291.505 (1991), and must include at least the "minimum contents of a medical evaluation" as set forth in 21 CFR 291.505(d)(3) (1991), such as, but not limited to: medical/narcotic use and/or abuse history, evidence of current physiologic dependence, a physical examination, determination of vital signs, required laboratory tests, examination of appearance and overall impression. Findings must be recorded in the patient's record in accordance with the standards set forth in 77 Ill. Adm. Code 2058.333, and the physician shall participate in individualized treatment planning.~~

~~B) The Ongoing Medical Examination includes face to face, medically necessary physician examinations including, but not limited to the following: required medical supervision of the patient's methadone medication regimen; required follow up of any physical or mental problem identified during the admission physical or arising subsequently; required reevaluation and modification of the individualized patient treatment plan; prescribing of medication and monitoring of significant changes in treatment planning; and must be documented by physician signature as involving face to face contact with the client. Medical necessity shall be determined by the physician based on medical diagnosis.~~

~~C) Reimbursement for physician services shall be made on a per encounter basis, using the rates established by IDPA for such services. Initial comprehensive examination reimbursement is limited to once a lifetime per recipient, per provider. Ongoing examinations are limited to those which are medically necessary.~~

~~2) Delivery of Methadone includes the prescribed dispensing and required reporting, by qualified medical staff, of an observed or take home dosage or dosages of methadone to an individual Medicaid recipient client, in accordance with 77 Ill. Adm. Code 2058.324 and 2058.369. Reimbursement shall be made per encounter using a rate based on dosage cost plus a standard delivery fee agreed to between the Department and IDPA.~~

~~3) Toxicology testing includes the collection, packaging, preparing and processing of urine specimens and testing in accordance with 77 Ill. Adm. Code 2058.366, 21 CFR 291.505(d)(2) (1991), and other pertinent state and federal laws. To be reimbursable, toxicology testing must be done either by a laboratory that is licensed by the Illinois Department of Public Health, pursuant to the Clinical Laboratory Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 621 101 et seq.) (210 ILCS 25) and the Clinical Laboratory Code, 77 Ill. Adm. Code 450, and if applicable 77 Ill. Adm. Code 2058.366, and/or be done by an approved drug testing machine at a facility certified pursuant to 77 Ill. Adm. Code 450 or exempt from such certification, either of which is testing done by or under contract with the certified methadone program. Reimbursement shall be determined by a cost based rate methodology, such rate to be calculated by the Department and approved by IDPA.~~

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 2090.70 Rate Setting

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a) The amount approved for payment for alcoholism and other drug abuse treatment is based on the category and amount of services required by and actually delivered to a recipient. The amount is determined in accordance with prospective rates developed by the Department and adopted by the Department of Public Aid. The adopted rate shall not exceed the charges to the general public.

b) Rates are cost-based and are established annually for each service. In order that costs may be determined, each provider shall submit, upon application for certification, the provider's annual audit for the prior fiscal year and two copies of the required statistical and financial information which shall be submitted on forms specified by the Department. These shall be submitted in accordance with Sections 2090.90 (c)(1) and (2) of this Part. Blank copies of the forms and instructions for its completion may be obtained by submitting a request in writing to:

Illinois Department of Alcoholism and Substance Abuse
Office of Purchased Care Development
222 South College, 2nd Floor
Springfield, IL 62704

c) Rates are generated through the application of formal methodologies specific to each category.

1) Outpatient services shall be reimbursed at an all-inclusive per client hour rate payable to the nearest quarter hour. Such services are defined as face-to-face counseling with a diagnosed client. No more than two client hours shall be reimbursed for any client during a 24 hour period, except as permitted by Section 2090.40(a)(5).

2) Intensive Outpatient services shall be reimbursed at an all-inclusive session rate: a day is defined as a minimum of three hours per 24 period. No more than one client session shall be reimbursed for any recipient during any 24 hour period.

3) Adolescent ~~Residential~~ residential rehabilitation services shall be reimbursed at an all-inclusive per diem rate. No more than one client day shall be reimbursed for any recipient during any 24 hour period.

~~4) Detoxification services shall be reimbursed at an all-inclusive per diem rate; however, admissions less than twelve hours in length shall be reimbursed at a per episode rate.~~

4) Day treatment services shall be reimbursed at an all-inclusive per diem rate exclusive of costs attributable to domiciliary services as specified in Section 2090.40(e)(2). No more than one client encounter shall be reimbursed for a recipient in any 24 hour period.

~~6) Day detoxification services shall be reimbursed at an all inclusive per diem rate which shall exclude costs attributable to domiciliary services as specified in Section 2090.40(f)(2). No more than one client encounter shall be reimbursed for a recipient in any 24 hour period.~~

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5) Ancillary psychiatric diagnostic services shall be reimbursed on a per encounter basis to psychiatrists at the practitioner's usual and customary charge, not to exceed the maximum established by the Department.

~~8) Ancillary Methadone services shall be reimbursed on a per service basis using methodology as set forth in each of the reimbursable categories described in Section 2090.40(f).~~

6) The provider shall not be reimbursed for more than one covered subacute alcoholism or other drug abuse service per client per day except for ancillary services which may be reimbursed in addition to one of the other covered services.

7) Outpatient and intensive outpatient services, which may be delivered in a group setting, shall be reimbursed only for ~~groups consisting of no more than~~ 12 clients supported by DASA funding (Medicaid or other).

d) Hospitals

The Department shall establish rates with hospitals delivering subacute services who request such certification and are certified pursuant to this Part. Rates shall be based upon the services definitions found in Section 2090.40(a), (b), (c), (d) and (de) of this Part, and shall be subject to the provisions of subsections (a), (b) and (c) of this Section.

(Source: Amended at 19 Ill. Reg _____, effective _____)

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1) Heading of the Part: Pay Plan

2) Code Citation: 80 Ill. Adm. Code 310

3) Section Numbers: Proposed Action:

310.230 Amended

4) Statutory Authority: Authorized by Section 8.2 of the Personnel Code (Ill. Rev. Stat. 1991, ch. 127, par. 63b108a.2) [20 ILCS 415/8a.2]

5) A Complete Description of the Subjects and Issues Involved: In Section 310.230, Part-time Daily or Hourly Special Services Rate, the hourly rates of the Conservation/Historic Preservation Workers are being upgraded at the request of the Department of Conservation.

The part-time hourly salary for the Conservation/Historic Preservation Worker will be $4.50 to 6.50; Conservation/Historic Preservation Worker (2nd season -- site interpretation) will be $4.64 to 6.50; and Conservation/Historic Preservation Worker (3rd season -- site interpretation) will be $4.78 to 6.50 per hour.

6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain any incorporations by reference? No.

9) Are there any proposed amendments pending to this Part? Yes

Section Numbers	Proposed Action	Ill. Reg. Citation
310.Appendix A, Table L	Amended	19 Ill. Reg. 764 (January 27, 1995)
310.230	Amended	19 Ill. Reg. 2365 (March 3, 1995)
310.290	Amended	19 Ill. Reg. 2365 (March 3, 1995)

10) Statement of Statewide Objectives: These amendments to the Pay Plan pertain only to State employees subject to the Personnel Code and do not set out any guidelines that are to be followed by local or other jurisdictional bodies within the State.

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking:

Mr. Michael Murphy
Department of Central Management Services

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Division of Technical Services
504 William G. Stratton Building
Springfield, Illinois 62706
Telephone: (217) 782-5601

12) Initial Regulatory Flexibility Analysis:

A) Date rule was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: The Department of Central Management Services' Pay Plan does not affect private businesses. Amendments made to the Pay Plan are not subject to any guidelines or regulations of the Department of Commerce and Community Affairs.

B) Types of small businesses affected: None. The Department of Central Management Services' Pay Plan extends only to Personnel Code employees under the jurisdiction of the Governor.

C) Reporting, bookkeeping or other procedures required for Compliance: None.

D) Types of professional skills necessary for compliance: None.

13) State reason(s) for this rulemaking if it was not included in either of the two (2) most recent regulatory agendas: This rulemaking was on the agency's January 1995 Regulatory Agenda.

The full text of the proposed amendment(s) begins on the next page.

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TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES
SUBTITLE B: PERSONNEL RULES, PAY PLANS, AND POSITION CLASSIFICATIONS
CHAPTER II: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

PART 310
PAY PLAN

SUBPART A: NARRATIVE

Section
310.20 Policy and Responsibilities
310.30 Jurisdiction
310.40 Pay Schedules
310.50 Definitions
310.60 Conversion of Base Salary to Pay Period Units
310.70 Conversion of Base Salary to Daily or Hourly Equivalents
310.80 Increases in Pay
310.90 Decreases in Pay
310.100 Other Pay Provisions
310.110 Implementation of Pay Plan Changes for Fiscal Year 1995
310.120 Interpretation and Application of Pay Plan
310.130 Effective Date
310.140 Reinstitution of Within Grade Salary Increases
310.150 Fiscal Year 1985 Pay Changes in Schedule of Salary Grades, Effective July 1, 1984 (Repealed)

SUBPART B: SCHEDULE OF RATES

Section
310.205 Introduction
310.210 Prevailing Rate
310.220 Negotiated Rate
310.230 Part-Time Daily or Hourly Special Services Rate
310.240 Hourly Rate
310.250 Member, Patient and Inmate Rate
310.260 Trainee Rate
310.270 Legislated and Contracted Rate
310.280 Designated Rate
310.290 Out-of-State or Foreign Service Rate
310.300 Educator Schedule for RC-063 and HR-010
310.310 Physician Specialist Rate
310.320 Annual Compensation Ranges for Executive Director and Assistant Executive Director, State Board of Elections
310.330 Excluded Classes Rate (Repealed)

SUBPART C: MERIT COMPENSATION SYSTEM

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Section
310.410 Jurisdiction
310.420 Objectives
310.430 Responsibilities
310.440 Merit Compensation Salary Schedule
310.450 Procedures for Determining Annual Merit Increases
310.455 Intermittent Merit Increase
310.456 Merit Zone
310.460 Other Pay Increases
310.470 Adjustment
310.480 Decreases in Pay
310.490 Other Pay Provisions
310.495 Senior Public Service Administrator System
310.500 Definitions
310.510 Conversion of Base Salary to Pay Period Units
310.520 Conversion of Base Salary to Daily or Hourly Equivalents
310.530 Implementation
310.540 Annual Merit Increase Guidechart for Fiscal Year 1995
310.550 Fiscal Year 1985 Pay Changes in Merit Compensation System, effective July 1, 1984 (Repealed)

APPENDIX A Negotiated Rates of Pay
TABLE A HR-190 (Department of Central Management Services - State of Illinois Building - SEIU)
TABLE B HR-200 (Department of Labor - Chicago, Illinois - SEIU)
TABLE C RC-069 (Firefighters, AFSCME)
TABLE D HR-001 (Teamsters Local #726)
TABLE E RC-020 (Teamsters Local #330)
TABLE F RC-019 (Teamsters Local #25)
TABLE G RC-045 (Automotive Mechanics, IFPE)
TABLE H RC-006 (Corrections Employees, AFSCME)
TABLE I RC-009 (Institutional Employees, AFSCME)
TABLE J RC-014 (Clerical Employees, AFSCME)
TABLE K RC-023 (Registered Nurses, INA)
TABLE L VR-004 (Illinois State Treasurer's Office Employees, Teamsters and IFT)
TABLE M RC-110 (Conservation Police Lodge)
TABLE N RC-010 (Professional Legal Unit, AFSCME)
TABLE O RC-028 (Paraprofessional Human Services Employees, AFSCME)
TABLE P RC-029 (Paraprofessional Investigatory and Law Enforcement Employees, IFPE)
TABLE Q RC-033 (Meat Inspectors, IFPE)
TABLE R RC-042 (Residual Maintenance Workers, AFSCME)
TABLE S HR-012 (Fair Employment Practices Employees, SEIU)
TABLE T HR-010 (Teachers of Deaf, IFT)
TABLE U HR-010 (Teachers of Deaf, Extracurricular Paid Activities)
TABLE V CU-500 (Corrections, Meet and Confer Employees)
TABLE W RC-062 (Technical Employees, AFSCME)

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TABLE X	RC-063 (Professional Employees, AFSCME)
TABLE Y	RC-063 (Educators, AFSCME)
TABLE Z	RC-063 (Physicians, AFSCME)
APPENDIX B	Schedule of Salary Grades - Monthly and Annual Rates of Pay for Fiscal Year 1995
APPENDIX C	Medical Administrator Rates for Fiscal Year 1995
APPENDIX D	Merit Compensation System Salary Schedule for Fiscal Year 1995
APPENDIX E	Teaching Salary Schedule (Repealed)
APPENDIX F	Physician and Physician Specialist Salary Schedule (Repealed)
APPENDIX G	Public Service Administrator Class Series Salary Schedule

AUTHORITY: Implementing and authorized by Section 8a.2 of the Personnel Code (Ill. Rev. Stat. 1991, ch. 127, par. 63b108a.2) [20 ILCS 415/8.2].

SOURCE: Filed June 28, 1967; codified at 8 Ill. Reg. 1558; emergency amendment at 8 Ill. Reg. 1990, effective January 31, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 2440, effective February 15, 1984; emergency amendment at 8 Ill. Reg. 3348, effective March 5, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 4249, effective March 16, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 5704, effective April 16, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 7290, effective May 11, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 11299, effective June 25, 1984; emergency amendment at 8 Ill. Reg. 12616, effective July 1, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 15007, effective August 6, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 15367, effective August 13, 1984; emergency amendment at 8 Ill. Reg. 21310, effective October 10, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 21544, effective October 24, 1984; amended at 8 Ill. Reg. 22844, effective November 14, 1984; emergency amendment at 9 Ill. Reg. 1134, effective January 16, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 1320, effective January 23, 1985; amended at 9 Ill. Reg. 3681, effective March 12, 1985; emergency amendment at 9 Ill. Reg. 4163, effective March 15, 1985, for a maximum of 150 days; emergency amendment at 9 Ill. Reg. 9231, effective May 31, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 9420, effective June 7, 1985; amended at 9 Ill. Reg. 10663, effective July 1, 1985; emergency amendment at 9 Ill. Reg 15043, effective September 24, 1985, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 3325, effective January 22, 1986; amended at 10 Ill. Reg. 3230, effective January 24, 1986; emergency amendment at 10 Ill. Reg. 8904, effective May 13, 1986, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 8928, effective May 13, 1986; emergency amendment at 10 Ill. Reg. 12090, effective June 30, 1986, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 13675, effective July 31, 1986; peremptory amendment at 10 Ill. Reg. 14867, effective August 26, 1986; amended at 10 Ill. Reg. 15567, effective September 17, 1986; emergency amendment at 10 Ill. Reg. 17765, effective September 30, 1986, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 19132, effective October 28, 1986; peremptory amendment at 10 Ill. Reg. 21097, effective December 9, 1986; amended at 11 Ill. Reg. 648, effective December 22, 1986; peremptory amendment at 11 Ill. Reg.

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3363, effective February 3, 1987; peremptory amendment at 11 Ill. Reg. 4388, effective February 27, 1987; peremptory amendment at 11 Ill. Reg. 6291, effective March 23, 1987; amended at 11 Ill. Reg. 5901, effective March 24, 1987; emergency amendment at 11 Ill. Reg. 8787, effective April 15, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 11830, effective July 1, 1987, for a maximum of 150 days; peremptory amendment at 11 Ill. Reg. 13675, effective July 29, 1987; amended at 11 Ill. Reg. 14984, effective August 27, 1987; peremptory amendment at 11 Ill. Reg. 15273, effective September 1, 1987; peremptory amendment 11 Ill. Reg. 17919, effective October 19, 1987; peremptory amendment at 11 Ill. Reg. 19812, effective November 19, 1987; emergency amendment at 11 Ill. Reg. 20664, effective December 4, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 20778, effective December 11, 1987; peremptory amendment at 12 Ill. Reg. 3811, effective January 27, 1988; peremptory amendment at 12 Ill. Reg. 5459, effective March 3, 1988; amended at 12 Ill. Reg. 6073, effective March 21, 1988; peremptory amendment at 12 Ill. Reg. 7783, effective April 14, 1988; emergency amendment at 12 Ill. Reg. 7734, effective April 15, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 8135, effective April 22, 1988; peremptory amendment at 12 Ill. Reg. 9745, effective May 23, 1988; emergency amendment at 12 Ill. Reg. 11778, effective July 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 12895, effective July 18, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 13306, effective July 27, 1988; corrected at 12 Ill. Reg. 13359; amended at 12 Ill. Reg. 14630, effective September 6, 1988; amended at 12 Ill. Reg. 20449, effective November 28, 1988; peremptory amendment at 12 Ill. Reg. 20584, effective November 28, 1988; peremptory amendment at 13 Ill. Reg. 8080, effective May 10, 1989; amended at 13 Ill. Reg. 8849, effective May 30, 1989; peremptory amendment at 13 Ill. Reg. 8970, effective May 26, 1989; emergency amendment at 13 Ill. Reg. 10967, effective June 20, 1989, for a maximum of 150 days; emergency amendment expired on November 17, 1989; amended at 13 Ill. Reg. 11451, effective June 28, 1989; emergency amendment at 13 Ill. Reg. 11854, effective July 1, 1989, for a maximum of 150 days; corrected at 13 Ill. Reg. 12647; peremptory amendment at 13 Ill. Reg. 12887, effective July 24, 1989; amended at 13 Ill. Reg. 16950, effective October 20, 1989; amended at 13 Ill. Reg. 19221, effective December 12, 1989; amended at 14 Ill. Reg. 615, effective January 2, 1990; peremptory amendment at 14 Ill. Reg. 1627, effective January 11, 1990; amended at 14 Ill. Reg. 4455, effective March 12, 1990; peremptory amendment at 14 Ill. Reg. 7652, effective May 7, 1990; amended at 14 Ill. Reg. 10002, effective June 11, 1990; emergency amendment at 14 Ill. Reg. 11330, effective June 29, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14361, effective August 24, 1990; emergency amendment at 14 Ill. Reg. 15570, effective September 11, 1990, for a maximum of 150 days; emergency amendment expired on February 8, 1991; corrected at 14 Ill. Reg. 16092; peremptory amendment at 14 Ill. Reg. 17098, effective September 26, 1990; amended at 14 Ill. Reg. 17189, effective October 2, 1990; amended at 14 Ill. Reg. 17189, effective October 19, 1990; amended at 14 Ill. Reg. 18719, effective November 13, 1990; peremptory amendment at 14 Ill. Reg. 18854, effective November 13, 1990; peremptory amendment at 15 Ill. Reg. 663, effective January 7, 1991; amended at 15 Ill. Reg. 3296, effective February 14,

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1991; amended at 15 Ill. Reg. 4401, effective March 11, 1991; peremptory amendment at 15 Ill. Reg. 5100, effective March 20, 1991; peremptory amendment at 15 Ill. Reg. 5465, effective April 2, 1991; emergency amendment at 15 Ill. Reg. 10485, effective July 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 11080, effective July 19, 1991; amended at 15 Ill. Reg. 13080, effective August 21, 1991; amended at 15 Ill. Reg. 14210, effective September 23, 1991; emergency amendment at 16 Ill. Reg. 711, effective December 26, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 3450, effective February 20, 1992; peremptory amendment at 16 Ill. Reg. 5068, effective March 11, 1992; peremptory amendment at 16 Ill. Reg. 7056, effective April 20, 1992; emergency amendment at 16 Ill. Reg. 8239, effective May 19, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 8382, effective May 26, 1992; emergency amendment at 16 Ill. Reg. 13950, effective August 19, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14452, effective September 4, 1992, for a maximum of 150 days; amended at 17 Ill. Reg. 238, effective December 23, 1992; peremptory amendment at 17 Ill. Reg. 498, effective December 18, 1992; amended at 17 Ill. Reg. 590, effective January 4, 1993; amended at 17 Ill. Reg. 1819, effective February 2, 1993; amended at 17 Ill. Reg. 6441, effective April 8, 1993; emergency amendment at 17 Ill. Reg. 12900, effective July 22, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 13409, effective July 29, 1993; emergency amendment at 17 Ill. Reg. 13789, effective August 9, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 14666, effective August 26, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 19103, effective October 25, 1993; emergency amendment at 17 Ill. Reg. 21858, effective December 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 22514, effective December 15, 1993; amended at 18 Ill. Reg. 227, effective December 17, 1993; amended at 18 Ill. Reg. 1107, effective January 18, 1994; amended at 18 Ill. Reg. 5146, effective March 21, 1994; peremptory amendment at 18 Ill. Reg. 9562, effective June 13, 1994; emergency amendment at 18 Ill. Reg. 11299, effective July 1, 1994, for a maximum of 150 days; peremptory amendment at 18 Ill. Reg. 13476, effective August 17, 1994; emergency amendment at 18 Ill. Reg. 14417, effective September 9, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16545, effective October 28, 1994; peremptory amendment at 18 Ill. Reg. 16708, effective October 28, 1994; amended at 18 Ill. Reg. 17191, effective November 21, 1994; amended at 19 Ill. Reg. 1024, effective January 24, 1995; peremptory amendment at 19 Ill. Reg. 2481, effective February 17, 1995; peremptory amendment at 19 Ill. Reg. 3073, effective February 17, 1995; amended at 19 Ill. Reg. _____, effective _____.

SUBPART B: SCHEDULE OF RATES

Section 310.230 Part-Time Daily or Hourly Special Services Rate

The rate of pay as approved by the Director of Central Management Services for persons employed on a consultative or part-time basis requiring irregular hours of work shall be as listed below, except the total compensation of an employee in any given month shall not exceed the monthly rate of Step 5 of the salary grade for the title as shown in the Schedule of Salary Grades (Appendix B) of

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this Part if the class title is subject to the Schedule of Salary Grades, or Step 5 of the negotiated salary range for classes of positions shown in Section 310.220, Subpart B, Schedule of Rates, or 75% of the maximum rate of those classes of positions subject to the provisions of the Merit Compensation System, Subpart C of this Pay Plan.

Account Technician II	11.00 to 14.08 (hourly) 83 to 106 (daily)
Apiary Inspector	32 to 50
Building/Grounds Laborer	4.25 to 6.00 (per hour)
Building/Grounds Lead I	4.25 to 7.00 (per hour)
Building/Grounds Lead II	5.25 to 8.00 (per hour)
Building/Grounds Maintenance Worker	5.00 to 6.00 (per hour)
Chaplain I	32 to 70
Chemist I	32 to 45
Conservation/Historic Preservation Worker	~~4.58 (per hour)~~ 4.50 to 6.50 (hourly)
Conservation/Historic Preservation Worker (2nd season -- site interpretation)	~~4.64 (per hour)~~ 4.64 to 6.50 (hourly)
Conservation/Historic Preservation Worker (3rd season -- site interpretation)	~~4.78 (per hour)~~ 4.78 to 6.50 (hourly)
Dentist I	70 to 150
Dentist II	100 to 185
Educator	32 to 60
Educator Aide	12 to 35
Guard II	67 to 84
Guard III	75 to 96
Hearing and Speech Coordinator	15 to 30 (per hour)
Hearings Referee	75 to 200
Janitor I	4.73 to 5.30 (per hour)
Labor Maintenance Lead Worker	5.00 to 6.00 (per hour)
Labor Relations Investigator	35 to 70
Laborer (Maintenance)	4.25 to 5.50 (per hour)
Maintenance Worker	4.25 to 5.00 (per hour)
Occupational Therapist Program Coordinator	40 to 160
Office Aid	4.25 to 9.34 (hourly) 42 to 70 (daily)
Office Assistant	4.25 to 10.78 (hourly) 42 to 81 (daily)
Office Associate	4.25 to 11.71 (hourly) 42 to 88 (daily)
Office Clerk	4.25 to 10.01 (hourly)

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Optometrist	61 to 75 (daily)
Optometrist	50 to 160 (daily)
Physician	15 to 35 (hourly)
Physician Specialist (A)	100 to 300
Physician Specialist (A)	100 to 325 (daily)
Physician Specialist (B)	20 to 60 (hourly)
Physician Specialist (B)	100 to 350 (daily)
Physician Specialist (C)	20 to 70 (hourly)
Physician Specialist (C)	100 to 360 (daily)
Physician Specialist (D)	20 to 75 (hourly)
Physician Specialist (D)	100 to 370 (daily)
Podiatrist	20 to 85 (hourly)
Psychologist I	50 to 125
Psychologist II	35 to 80
Psychologist III	40 to 125
Recreation Worker I	40 to 150
Recreation Worker I	32 to 40
Registered Nurse I	5.33 (per hour)
Registered Nurse I (2nd or 3rd shift)	39 to 54 41 to 56
Registered Nurse I (Cook County)	43 to 58
Registered Nurse I (Cook County - 2nd or 3rd shift)	44 to 59
Registered Nurse II	43 to 58
Registered Nurse II (2nd or 3rd shift)	44 to 59
Registered Nurse II (Cook County)	45 to 60
Registered Nurse II (Cook County - 2nd or 3rd shift)	47 to 62
Social Worker II	35 to 75
Social Worker III	35 to 80
Student Worker	4.25 to 8.00 (per hour)
Tax Examiner	9.69 to 12.21 (hourly)
	73 to 92 (daily)
Technical Advisor II	32 to 35 (per hour)
Technical Advisor III	32 to 60 (per hour)
Technical Advisor IV	50 to 80 (per hour)
Veterinarian II	95 to 130 (daily)

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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1) Heading of the Part: Consignment of Licenses and Stamps

2) Code Citation: 17 Ill. Adm. Code 2520

3)

Section Numbers:	Proposed Action:
2520.10	Amendments
2520.20	Amendments
2520.30	Amendments
2520.40	Amendments
2520.50	Amendments

4) Statutory Authority: Implementing and authorized by Sections 1.4, 3.1, 3.2, 3.37, 3.38 and 3.39 of the Wildlife Code [520 ILCS 5/1.4, 3.1, 3.2, 3.37, 3.38 and 3.39] and Sections 1-125, 20-5, 20-10, 20-30, 20-45, 20-55 and 20-120 of the Fish and Aquatic Life Code [515 ILCS 5/1-125, 20-5, 20-10, 20-30, 20-45, 20-55 and 20-120].

5) A complete description of the subjects and issues involved: With the introduction in recent years of new stamps and licenses plus the enactment of license fee increases, the average asset value of license vendor account consignments has increased some 60%. This increase has resulted in many small volume accounts being placed into the large volume license account category with unnecessary added work for those small businesses and the License Office.

To address this issue, the remittance schedule is being adjusted to reposition small volume sales accounts into the small vendor account category. The dollar value used in identifying small volume sales accounts for a total year's consignment is being changed from consignment values up to $9,999.99 to consignment values up to $15,999.99.

6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

9) Are there any other proposed amendments pending on this part? No

10) Statement of statewide policy objectives: This rule has no impact on local governments.

11) Time, place and manner in which interested persons may comment on this proposed rulemaking: Comments on the proposed rule may be submitted in writing for a period of 45 days following publication of this notice to:

Jack Price

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Department of Conservation
524 S. Second Street, Room 430
Springfield, IL 62701-1787
(217) 782-1809

12) Initial regulatory flexibility analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Persons selling licenses and stamps.

B) Reporting, bookkeeping or other procedures required for compliance: Vendors must keep track of licenses and stamps sold and remit the proper fees for such sales. Unsold licenses and stamps must be returned at the end of the year.

C) Types of professional skills necessary for compliance: No professional skills are required.

13) State reason(s) for this rulemaking if it was not included in the two (2) most recent regulatory agendas: A Regulatory Agenda was not submitted for this Part for the period January 1-June 30, 1995 because the rule was not scheduled to be amended. The Department determined that this Part should be amended after receiving input from the public requesting the changes.

The full text of the proposed amendments begins on the next page:

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NOTICE OF PROPOSED AMENDMENTS

TITLE 17: CONSERVATION
CHAPTER I: DEPARTMENT OF CONSERVATION
SUBCHAPTER f: ADMINISTRATIVE SERVICES

PART 2520
CONSIGNMENT OF LICENSES-~~AND~~, STAMPS AND PERMITS

Section
2520.10 Consignment Requirements
2520.20 Issuing Licenses-~~and~~, Stamps and Permits
2520.30 Terms
2520.40 Credit to Vendor Accounts
2520.50 Issuance of Replacement Hunting, Fishing and Trapping Licenses -~~and~~, Stamps and Permits

AUTHORITY: Implementing and authorized by Sections 1.4, 3.1, 3.2, 3.37, 3.38 and 3.39 of the Wildlife Code (Ill. Rev. Stat. 1991, ch. 61, pars. 1.4, 3.1, 3.2, 3.37, 3.38 and 3.9) [520 ILCS 5/1.4, 3.1, 3.2, 3.37, 3.38 and 3.39] and Sections 1-125, 20-5, 20-10, 20-30, 20-45, 20-55 and 20-120 of the Fish and Aquatic Life Code (Ill. Rev. Stat 1991, ch. 56, pars. 1-125, 20-5, 20-10, 20-30, 20-45, 20-55 and 20-120) [515 ILCS 5/1-125, 20-5, 20-10, 20-30, 20-45, 20-55 and 20-120].

SOURCE: Adopted and codified at 7 Ill. Reg. 8760, effective July 15, 1983; amended at 8 Ill. Reg. 5660, effective April 16, 1984; amended at 9 Ill. Reg. 14626, effective September 17, 1985; amended at 11 Ill. Reg. 4633, effective March 10, 1987; amended at 15 Ill. Reg. 7653, effective May 7, 1991; amended at 16 Ill. Reg. 8479, effective May 26, 1992; amended at 18 Ill. Reg. 9991, effective June 21, 1994; amended at 19 Ill. Reg. _____, effective _____.

Section 2520.10 Consignment Requirements

a) The Department of Conservation (DOC) has the authority to designate agents to sell licenses, stamps and permits on behalf of the Department. DOC consigns hunting, fishing, trapping and Ginseng Harvester licenses, and migratory waterfowl, salmon and wildlife conservation stamps, and deer archery combination permits, hereinafter referred to as licenses-~~and~~, stamps and permits, for sale by county, city, village, township and incorporated town clerks, upon receipt of their completed application and elected official license vendor contract, and fulfillment of requirements set forth in this Part. The Department also consigns the licenses-~~and~~, stamps and permits to other persons, hereinafter referred to as "direct agents", upon receipt of their completed application, license vendor contract, evidence of financial responsibility, and fulfillment of the requirements set forth in this Part. The term "direct agent" means all persons authorized by the Department to sell licenses-~~and~~, stamps and permits

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other than elected or appointed officials and department employees. License vendors, including employees of the Department selling licenses--~~and~~, stamps and permits, shall collect an issuing fee in addition to the license-~~and~~, stamp and permit fee as provided in ~~[~~Ill. Rev. Stat. 1991, ch. 56, par. 20-120~~]~~ 515 ILCS 5/20-120] and ~~ch. 61, par. 3.37~~ [520 ILCS 5/3.37] as follows: 75 cents for each Sportsmen's Combination license and non-resident hunting license, and 50 cents for all other licenses-~~and~~, stamps and permits authorized by the above statutes. All licenses--~~and~~, stamps and permits consigned and fees collected from the sale of licenses-~~and~~, stamps and permits (except the authorized issuing fee) remain the property of the State of Illinois. Funds received from the sale of licenses, ~~and~~ stamps and permits (except the authorized issuing fee) shall not be directed to any purpose other than remittance to the Department.

b) County, city, village, township and incorporated town clerks may appoint sub-agents within the territorial area for which they are elected or appointed. Elected or appointed officials and Department employees selling licenses-~~and~~, stamps and permits are liable to the State for all licenses-~~and~~, stamps and permits consigned to their account, including any licenses-~~and~~, stamps and permits furnished by a clerk to any sub-agent. Any clerk appointing sub-agents must notify the Department, within 10 days following the appointment, the names and mailing addresses of such sub-agents. No part of the issuing fees collected may be retained as personal compensation by the clerk. Issuing fees may be divided between the clerk and appointed sub-agents other than employees of the Clerk's office, but in no case may any clerk and/or sub-agent charge an issuing fee or fees totaling more than the amounts set out in Section 2520.10 of the Part. DOC assumes no liability for any license, stamp or permit furnished by any elected or appointed clerk to any sub-agent.

c) All direct agents, including concessionaires holding contracts with the Department shall be required to furnish DOC with evidence of financial responsibility. Such evidence shall be in the form of a surety bond, irrevocable letter of credit or certificate of deposit, in an amount equal to the value of licenses -~~and~~, stamps and permits consigned. Surety bonds and letters of credit shall be on a form furnished by and approved by DOC, with surety or sureties satisfactory to DOC, conditioned upon such agents paying to the State of Illinois all monies becoming due by reason of the sale of licenses~~and~~, stamps and permits. No direct agent may appoint sub agents.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 2520.20 Issuing Licenses-~~and~~, Stamps and Permits

a) License, stamp and permit forms shall be filled out completely, accurately and legibly at the time of issuance, and the full amount

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shall be collected as shown on the license face. In the case of stamps, the license fee plus the authorized issuing fee shall be collected, if the issuing fee is not shown on the face of the stamp. Vendors shall not back-date or issue an undated license.

b) The application portion of each license shall be retained by the issuing clerk or agent until the license issued expires, except in the case of Trapping licenses, Waterfowl stamps, Habitat stamps-~~and~~, Ginseng Harvester licenses and deer archery combination permits, for which the completed application must accompany the remittance.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 2520.30 Terms

a) When funds received in payment for licenses-~~and~~, stamps and permits are deposited in an interest bearing account and where fees collected by a vendor are determined to be late to the department according to the remittance schedule in Section 2520.30(c), interest that has accrued through an interest bearing license account on the overdue funds will be remitted to the Department by separate check along with fees collected from the sale of such licenses-~~and~~, stamps and permits.

b) All license vendors shall be required to remit to the Department, according to the schedule in subsection (c) below, all funds received from the sale of licenses--~~and~~, stamps and permits during the preceeding remittance period except the authorized issuing fee. Vendors having licenses-~~and~~, stamps and permits on hand for sale, but who have sold none during the remittance period, shall report this fact to the Department according to the remittance schedule by the use of a "no sales" report, furnished by the Department.

c) The remittance schedules are as follows:

1) Schedule I: For vendors having sold licenses--~~and~~, stamps and permits with a value of ~~$10,000~~ $16,000 or more during a prior license year, remittance periods shall be from the 1st through the 15th of each month and the 16th through the last day of each month. Remittance shall be made to the Department no later than the 5th and 20th of each month, for all licenses-~~and~~, stamps and permits sold during the previous remittance period.

2) Schedule II: For vendors having sold licenses--~~and~~, stamps and permits of a value of ~~$9,999.99~~ $15,999.99 or less during the previous license year, the remittance period shall be each month. Remittance shall be made to the Department no later than the 10th of each month for all licenses--~~and~~, stamps and permits sold during the previous month.

d) Accounts more than one remittance period past due shall have additional license consignments withheld until the account is current. Accounts two remittance periods or more past due will cause the Department to cancel or withdraw the issuance of licenses through such

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clerks or agents. In the case of secured agents, payment will be demanded from the security company. No installment payment agreements will be accepted by DOC except pursuant to judgment decrees.

e) Within 30 days after the expiration of the time in which any class of licensee~~s~~, stamp or permit is usable, the final payment for licenses and, stamps and permits sold shall be made in full to the Department, and all unsold or void licenses, stamps and permits shall be returned to the Department. Accounts not closed out within the 30 days specified shall be suspended or terminated, and referred to the ~~agent's sending~~ security company ~~or~~ for action or referral to other agencies for assistance.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 2520.40 Credit to Vendor Accounts

a) Void or unsold licenses-~~and~~, stamps and permits shall be returned to the Department for credit to the vendor account. Credit for void or unsold licenses-~~and~~, stamps and permits will be allowed only when the original license, stamp or permit is returned. The application portion of the license, stamp or permit will not be accepted for credit.

b) Credit to vendor accounts for void licenses-~~and~~, stamps and permits shall be denied if the license-~~or~~, stamp or permit shows signs of use, such as encasement in plastic or other signs of use. The license and permit supervisor is responsible for this determination, and if credit is denied, the Supervisor, License Section, shall cause the vendor to be notified of this action.

c) No person selling licenses-~~and~~, stamps and permits is required to remit for any licensee~~or~~, stamps or permits stolen by forcible entry or destroyed by a fire in the premises where such licenses-~~and~~, stamps and permits are kept, if he submits an affidavit to the Department describing the circumstances of such theft or cause of such destruction and listing the type and numbers of licenses, stamps and permits so destroyed. An official report of the responding to the call or police if a robbery) must also be submitted.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 2520.50 Issuance of Replacement Hunting, Fishing and Trapping Licenses and, Stamps and Permits

a) The Department will issue replacements for lost hunting, fishing, Sportsman's Combination, Ginseng harvester, commercial licenses and permits, trapping licenses--~~and~~, Illinois stamps and deer archery combination permits. A fee of $3.00 per license-~~or~~, stamp or permit

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will be charged to defray the cost of handling.

b) The Department will issue replacements at no cost when the Department loses the sportman's hunting, fishing, Sportsman's Combination, Ginseng Harvester, ~~or~~ trapping licenses ~~or~~, stamps or deer archery combination permits.

c) The procedure for obtaining a replacement license-~~or~~, stamp or permit is as follows:

1) Individual loss - The individual requesting the replacement should obtain from the vendor from which the original license-~~or~~, stamp or permit was purchased, a copy (or the original) of the licensee~~or~~, stamp or permit application. If the application is unavailable, the individual may obtain ~~an--"Application--for Replacement---license"~~ a "Replacement License/Stamp Permit Application" from any license vendor or the Department. ~~An "Application----for-----Replacement-----license"~~ "Replacement License/Stamp/Permit Application" must be notarized to ensure that the application is accurate and non-fraudulent. The copy of the original application, or properly completed and notarized ~~"Application----for----Replacement-----license;"~~ "Replacement License/Stamp/Permit Application" should then be forwarded with the $3.00 fee per licensee~~or~~, stamp or permit to:--~~Department--of Conservation;--Replacement-license-Section;-524-S.-Second-Street; Springfield,--IL--62706.---This--section--will--then--issue---the replacement---license--and/or--stamp(s).~~ any of the following offices:

A) Illinois Department of Conversation
P.O. Box 19459
Springfield, IL 62794-9459

B) Illinois Department of Conservation
2612 Locust Street
Sterling, IL 61081

C) Illinois Department of Conservation
110 James Road
Spring Grove, IL 60081

D) Illinois Department of Conservation
2005 Round Barn Road
Champaign, IL 61821

E) Illinois Department of Conservation
4521 Alton Commerce Parkway
Alton, IL 62002

F) Illinois Department of Conservation
11731 State Highway 37
Benton, IL 62812

G) Illinois Department of Conservation
100 West Randolph
Suite 4 - Room 300
Chicago, IL 60601

2) Department loss - The Department location requesting the

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replacement should complete on agency letterhead a request for a replacement and forward the request to ~~the--Replacement--License Section:~~ Department of Conservation, Replacements, 524 S. Second Street, Springfield, IL 62701. The request should be completed in triplicate with one copy retained at the location and one copy given to the person whose license ~~and/or stamp(s) were~~, stamp or permit was lost. This copy of the request will allow the person to hunt or fish in the interim between receiving a replacement. Information contained in the replacement request letter must include:

A) date of the letter;

B) indication that the letter may be used by the person in lieu of a license, stamp or permit for up to 30 days from the date on the letter;

C) Department location requesting the replacement (including address and contact phone number);

D) the name, complete mailing address, county of residence, date of birth, height, weight, hair color, eye color and daytime phone number of the person receiving the replacement;

E) indication of what licenses ~~and/or~~, stamps or permits need to be replaced;

F) the printed or typed names and signatures and the date of signature of the authorized persons at the Department location issuing the replacement letter and the location supervisor.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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1) Heading of the Part: Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)

2) Code Citation: 89 Ill. Adm. Code 149

3)

Section Numbers:	Proposed Action:
149.5	Amendment
149.25	Amendment
149.100	Amendment
149.105	Amendment
149.125	Amendment
149.140	Repeal
149.150	Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, par. 12-13) [305 ILCS 5/12-13]

5) Complete Description of the Subjects and Issues Involved: These proposed amendments affect the Department's rules concerning the Diagnosis Related Grouping (DRG) Prospective Payment System (PPS) for inpatient hospital services. The proposed amendments bring the Department into compliance with statutory requirements and changes regarding the Medicare methodology utilized in computing outlier adjustment payments, and with provisions of Public Act 88-554 concerning the elimination of certain adjustment payments.

Section 149.105 contains provisions regarding the cost of care beyond thresholds specified by the Department, or outlier provisions. According to federal regulations, Medicaid outlier adjustment payments must be calculated according to current Medicare methodology and changes are being made to update this Section in accordance with Medicare standards. In Section 149.5 definitions for new terms are being proposed which pertain to these Medicare revisions. The terms "marginal cost factor" and "cost outlier threshold" shall bear the same meanings as those employed by Medicare.

Other proposed amendments throughout these rules are necessary to comply with provisions of Public Act 88-554, concerning certain add-on payments. Effective July 1, 1995, adjustment payments for health care education, uncompensated care, kidney acquisition costs, and non-physician anesthesia shall be eliminated. On this basis, Section 149.140 which addresses the methodology for determining primary care access health care education payments is being proposed for repeal.

It is expected that these proposed amendments will result in a reduction in Department expenditures of approximately $119.1 million for Fiscal Year 1996.

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9) Will these proposed amendments replace emergency amendments currently in effect? No

) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: These proposed amendments do not affect units of local government.

11) Time, place, and manner in which interested persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to Joanne Jones, Bureau of Rules and Regulations, Illinois Department of Public Aid, 100 South Grand Ave. E., 3rd Floor, Springfield, Illinois 62762 (Phone: (217) 524-3215). The Department requests the submission of written comments within 30 days after the publication of this notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

Any interested persons may review these amendments at the Department of Public Aid's local offices located in each county (except Cook County). In Cook County, the amendments may be reviewed at the Office of the Director, Illinois Department of Public Aid, 310 South Michigan Avenue, Suite 1700, Chicago, Illinois. The Amendments may be reviewed at all offices Monday through Friday from 8:30 A.M. until 5:00 P.M. These copies of the amendments are being made available for review in accordance with federal requirements at 42 CFR 447.205.

These proposed amendments may have an impact on small businesses, small municipalities, and not-for-profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not-for-profit corporations as part of any written comments they submit to the Department.

12) Initial regulatory flexibility analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Hospitals

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B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) State reasons for this rulemaking if it was not included in either of the two most recent regulatory agendas: The reasons for this rulemaking are fully described above in the complete description of the subjects and issues involved. This rulemaking was inadvertently omitted when the two most recent regulatory agendas were published.

The full text of the Proposed Amendments begins on the next page:

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NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 149
DIAGNOSIS RELATED GROUPING (DRG) PROSPECTIVE PAYMENT SYSTEM (PPS)

Section
149.5 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
149.10 Applicability of Other Provisions
149.25 General Provisions
149.50 Hospital Services Subject to and Excluded from the DRG Prospective Payment System
149.75 Conditions for Payment Under the DRG Prospective Payment System
149.100 Basic Methodology for Determining DRG Prospective Payment Rates
149.105 Payment For Outlier Cases
149.125 Special Treatment of Certain Facilities
149.140 Methodology for Determining Primary Care Access Health Care Education Payments (Repealed)
149.150 Payments to Hospitals Under the DRG Prospective Payment System
149.175 Payments to Contracting Hospitals (Repealed)
149.200 Admitting and Clinical Privileges (Repealed)
149.205 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Repealed)
149.225 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Repealed)
149.250 Contract Monitoring (Repealed)
149.275 Transfer of Recipients (Repealed)
149.300 Validity of Contracts (Repealed)
149.305 Termination of ICARE Contracts (Repealed)
149.325 Hospital Services Procurement Advisory Board (Repealed)

AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 6503-1 et seq.) [20 ILCS 2215/Art. 3] and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13) [305 ILCS 5/Arts. III, IV, V, VI, VII and 12-13].

SOURCE: Recodified from 89 Ill. Adm. Code 140.940 thru 140.972 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. at 12095, effective July 15, 1988; amended at 13 Ill. Reg. 554, effective January 1, 1989; amended at 13 Ill. Reg. 15070, effective September 15, 1989; amended at 15 Ill. Reg. 1826, effective January 28, 1991; emergency amendment at 15 Ill. Reg. 16308, effective November 1, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 6195, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11937, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14733, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19868,

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effective December 7, 1992; amended at 17 Ill. Reg. 3217, effective March 1, 1993; emergency amendment at 17 Ill. Reg. 17275, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3378, effective February 25, 1994; amended at 19 Ill. Reg. _____, effective _____.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE

Section 149.5 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)

a) Sections 149.25 through 149.150 describe:
   1) The basis of payment for inpatient hospital services under the DRG PPS and set forth the general basis for the system;
   2) Classifications of hospitals that are included and excluded from the DRG PPS and the requirements governing inclusion or exclusion of hospitals in the system as a result of changes in their classification;
   3) Conditions that must be met for a hospital to receive payment under the DRG PPS;
   4) The methodology by which DRG prospective rates are determined;
   5) The methodology for determining additional payments for outlier cases;
   6) The rules for special treatment of certain facilities; and
   7) The types, amounts and methods of payment to hospitals under the DRG PPS.

b) Notwithstanding any other provisions of this Part, reimbursement to hospitals for services provided October 1, 1992, through March 31, 1994, shall be as follows:
   1) Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1992, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the base inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under Part 149.
   2) Exceptions. The provisions of subsection (b)(1) above shall not apply to:
      A) Hospitals reimbursed under 89 Ill. Adm. Code 148.82, 148.160, or 148.170. Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.82, 148.160, or 148.170, as applicable.
      B) Hospitals reclassified as rural hospitals as described in 89 Ill. Adm. Code 148.40(f)(4). Reimbursement for such hospitals shall be in accordance with 89 Ill. Adm. Code 148.40(f)(4) and 148.260, or Section 149.100(c)(1)(A), whichever is applicable.
      C) The inpatient payment adjustments described in 89 Ill. Adm.

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Code 148.120, 148.150, and 148.290. Reimbursement for such inpatient payment adjustments shall be in accordance with 89 Ill. Adm. Code 148.120, 148.150, and 148.290, and shall be in addition to the base inpatient payment rate described in subsection (b)(1) above.

c) Definitions
Unless specifically stated otherwise, the definitions of terms used in this Part are as follows:

1) "DRG grouper" means:
   A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare DRG grouper in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).
   B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare DRG grouper which is in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(1).

2) "Medicare weighting factor" means:
   A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Medicare DRG weighting factors in effect on September 1, 1992, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).
   B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Medicare DRG weighting factors in effect 90 days prior to the date of admission, adjusted for differences in Medicare and Medicaid policies and populations, as described in Section 149.100(a)(2).

3) "PPS Pricer" means:
   A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the HCFA Medicare PPS Pricer, Version 92.0.
   B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the HCFA Medicare PPS Pricer version that is in effect 90 days prior to the date of admission.

4) "Marginal Cost Factor" means:
   A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the marginal cost factor shall be the same as that employed by Medicare on September 1, 1992.
   B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the marginal cost factor shall be the same as that employed by Medicare 90 days prior to the date of admission.

5) "Cost Outlier Threshold" means:
   A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the cost outlier threshold shall be the same as that employed by Medicare on September 1, 1992, adjusted for the differences in Medicare and Medicaid policies and population, as described in Section 149.100(a)(1).
   B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the cost outlier threshold/fixed loss threshold shall be the same as that employed by Medicare 90 days prior to the date of admission.

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 149.25 General Provisions

a) Basis of Payment
   1) Payment on a Per Discharge Basis
      A) Under the DRG PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.
      B) The DRG prospective payment rate for each discharge (as defined in subsection (b) below) is determined according to the methodology described in Sections 149.100 and 149.150, as appropriate. An additional payment is made, in accordance with Sections 149.105, and 149.125--~~and 149.140~~, as appropriate. The rates paid shall be those in effect on the date of admission.
   2) Payment in Full
      A) The DRG prospective payment amount paid for inpatient hospital services is the total Medicaid payment for the inpatient operating costs (as described in subsection (a)(3) below) incurred in furnishing services covered under the Medicaid Program.
      B) Except as provided for in subsection (b) below, the full DRG prospective payment amount, as determined under Sections 149.100 and 149.150, as appropriate, is made for each stay during which there is at least one Medicaid eligible day of care.
   3) Inpatient Operating Costs. The DRG PPS provides a payment amount for inpatient operating costs, including:
      A) Operating costs for routine services (as described in 42 CFR 413.53(b), revised as of September 1, 1990), such as the costs of room, board, and routine nursing services;
      B) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;
      C) Special care unit operating costs (intensive care type unit services as described in 42 CFR 413.53(b), revised as of September 1, 1990); and
      D) Malpractice insurance costs related to services furnished to inpatients.

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E) Hospital-based physician costs as described in Section 149.75(h)(1)(A).

4) Excluded Costs Services. The following inpatient hospital costs are excluded from the DRG prospective payment amounts:

A) Transplantation cost, including acquisition cost incurred by approved transplantation centers as described in 89 Ill. Adm. Code 148.82. Kidney and cornea transplant costs shall be reimbursed under the appropriate methodology described in Sections 149.100 and 149.150 or in 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300. ~~Kidney acquisition costs shall be reimbursed in accordance with Section 149.150(c)(5).~~

B) Costs of psychiatric services incurred by a provider enrolled with the Department to provide those services (category of service 21). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).

C) Costs of non emergency psychiatric services incurred by a provider that is not enrolled with the Department to provide those services (category of service 21). Such services shall not be eligible for reimbursement.

D) Costs of emergency psychiatric services exceeding the maximum of three days emergency treatment incurred by a provider that is not enrolled with the Department to provide those services (DRGs 424-432). Such services exceeding the maximum of three days shall not be eligible for reimbursement.

E) Costs of physical rehabilitation services incurred by a provider enrolled with the Department to provide those services (category of service 22). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).

F) Costs of rehabilitation for drug and alcohol abuse (DRG 436 and that part of DRG 437 apportioned to rehabilitation). Such services shall be reimbursed under 89 Ill. Adm. Code 148.340 through 148.390.

5) Additional Payments to Hospitals. In addition to payments based on the DRG prospective payment rates, hospitals will receive payments for the following:

A) A typically long or extraordinary costly (outlier) cases, as described in Section 149.105.

B) Certain costs excluded from the prospective payment rate under subsection (a)(4) above.

C) The cost of serving a disproportionately high share of low income patients (as defined and determined in Section 149.125(a)(2)).

D) ~~Uncompensated care costs (as defined and determined in Section 149.125(a)(3)).~~

E) Specific inpatient payment adjustments (as defined and determined in Section 149.125(a)(3) ~~149.125(a)(4)~~).

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~~F) Health care education payments (as defined and determined in Section 149.140).~~

~~G) Certified registered nurse anesthetist (CRNA) costs in accordance with Section 149.150(c)(3).~~

~~H) Kidney acquisition costs in accordance with Section 149.150(c)(5).~~

b) Discharges and Transfers

1) Discharges. A hospital inpatient is considered discharged when any of the following occurs:

A) The patient is formally released from the hospital except when the patient is transferred to another hospital or a distinct part unit as described in Section 149.50(d) (see subsection (b)(2) below).

B) The patient dies in the hospital.

2) Transfers. A hospital inpatient is considered transferred when the patient is placed in the care of another hospital or a distinct part unit as described in Section 149.50(d).

3) Payment in Full to the Discharging Hospital. The hospital discharging an inpatient (subsection (b)(1)(A) above) is paid in full, in accordance with subsection (a)(2) above unless the discharging hospital or distinct part unit is excluded from the DRG PPS as described in Section 149.50(b), (c) and (d). In the event the discharging hospital or distinct part unit is excluded or exempted from the DRG PPS, that hospital or distinct part unit shall receive payment in full in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.

4) Payment to a Hospital Transferring an Inpatient to Another Hospital or District Part Unit

A) A hospital reimbursed under the DRG PPS that transfers an inpatient, under the circumstances described in subsection (b)(2), is paid a per diem rate for each day of the patient's stay in that hospital but the total reimbursement shall not exceed the amount that would have been paid under Section 149.100 if the patient had been discharged. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under Section 149.100) by the geometric length of stay for the specific DRG to which the case is classified.

B) Except, if a discharge is classified into DRGs 385 or 985 (neonates, died or transferred to another acute care facility) or DRG 456 (burns, transferred to another acute care facility), and the hospital is reimbursed under the DGR PPS, the transferring hospital is paid in accordance with subsection (a)(2).

C) A transferring hospital reimbursed under the DRG PPS may qualify for an additional payment for extraordinarily high cost cases that meet the criteria for cost outliers as described in Section 149.105.

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D) A hospital or distinct part unit excluded from the DRG PPS, as described in Section 149.50(b), (c) or (d), that transfers an inpatient under the circumstances described in subsection (b)(2) of this Section, is reimbursed in accordance with 89 Ill. Adm. Code 148.160, 148.170 or 148.250 through 148.300.

c) Admission Prior to September 1, 1991. With respect to admissions prior to September 1, 1991, hospitals will receive their per diem reimbursement rate that was in effect July 1, 1991 for each covered day of care provided through the discharge of the patient.

d) DRG Classification System

1) The Department will utilize the DRG Grouper, as described in Section 149.5(c)(1), modified to handle additional DRGs and revised ICD-9-CM codes, as defined by the Department, to place claims into DRG payment classifications.

2) The Department will define additional DRGs that, for hospitals designated as Level III perinatal centers by the Illinois Department of Public Health, replace DRG 385 (neonates, died or transferred to another acute care facility), DRG 386 (extreme immaturity or respiratory distress syndrome, neonate), DRG 387 (prematurity with major problems) and DRG 389 (full term neonate with major problems).

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 149.100 Basic Methodology for Determining DRG Prospective Payment Rates

a) DRG Classification and Weighting Factors

1) DRG Classification. The Department will utilize the DRG Grouper, as described in Section 149.5(c)(1), to classify inpatient hospital discharges by diagnosis related groups (DRGs) as defined by federal regulation for the Medicare Program (42 CFR 412), with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.

2) DRG Weighting Factors

A) Except as provided in subsections (a)(2)(B) through (a)(2)(E) below, the Illinois Medicaid weighting factor for each DRG shall equal the Medicare weighting factor, as described in Section 149.5(c)(2), for that group, multiplied by a fraction, the numerator of which is the Medicaid geometric mean length of stay and the denominator of which is the Medicare geometric mean length of stay for that group. In making that calculation, the Department shall:

i) Use the Medicare geometric mean length of stay for each diagnostic-related group as determined by the

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Health Care Financing Administration of the United States Department of Health and Human Services.

ii) Calculate the Medicaid geometric mean length of stay for each diagnostic-related group using the same methodology employed to calculate the Medicare geometric mean length of stay and using data obtained from the Illinois Health Care Cost Containment Council or the Definitions data bases.

B) The Illinois weighting factors for neonatal discharges (Medicare-defined DRGs 385-391 and Illinois-defined DRGs for Level III perinatal centers) shall be the product of the ratio of the mean cost per discharge (defined below) of the given DRG to the mean cost per discharge for DRG 391 (normal newborn) and the Medicare scaling factor (defined below), such that the Illinois and Medicare weighting factors for DRG 391 are the same.

i) Mean cost per discharge, for any DRG, is defined as the sum of the product of charges, as reported by a hospital on claims paid by the Department, less costs ~~listed as otherwise reimbursed under Section 149.150(c);~~ for capital, direct and indirect medical education, updated to the current rate year using the national hospital market basket price proxies (DRI) and the hospital's cost to charge ratio, as derived from the hospital's most recent audited cost report divided by the number of discharges for that DRG.

ii) Medicare scaling factor is defined as the Medicare weighting factor for DRG 391 (normal newborns).

C) The Illinois weighting factors for psychiatric discharges (DRGs 424-432) shall be computed as specified in subsections (a)(1) and (a)(2) except, prior to computing the Medicaid geometric mean length of stay for those DRGs, all lengths of stay longer than three (3) days are to be set at three (3) days.

D) The Illinois weighting factors for DRGs that will not be paid through the DRG PPS are zero (0.0000). Those include DRG 103, heart transplant; DRG 462, rehabilitation; DRG 480, liver transplant; DRG 436, alcohol/drug dependence with rehabilitation therapy; DRG 481, bone marrow transplant; DRG 495, lung transplant.

E) Except for DRGs otherwise specified in subsections (a)(2)(B) through (a)(2)(D), the Illinois weighting factors for DRGs for which available historic discharge data are sparse, fewer than 100 records, shall be computed using an alternate methodology.

i) For rate periods beginning on or after October 1, 1992, for those DRGs with 32 or more records available, the Illinois weighting factor shall be set

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at the midpoint between the weight calculated using the methodology in subsection (a)(2)(A) and the Medicare weighting factor, as described in Section 149.5(c)(2).

ii) For those DRGs with fewer than 32 records available, the Illinois weighting factor shall be set equivalent to the Medicare weighting factor, as described in Section 149.5(c)(2).

3) Assignment of Discharges to DRGs. The Department will establish a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG, based on essential data abstracted from the inpatient bill for that discharge.

A) The classification of a particular discharge will, as appropriate, be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

B) Each discharge will be assigned to only one DRG (related, except as provided in subsection (a)(3)(C), to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

C) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be subject to prepayment review for validation and reverification. The Definitions DRG classification system will provide a DRG, and an appropriate weighting factor, for cases for which the unrealted diagnosis and procedure are confirmed.

4) Review of DRG Assignment

A) A hospital has 60 days after the date of the remittance advice indicating initial assignment of a discharge to a DRG to request a review of the assignment. The hospital may submit additional information as a part of its request.

B) The Department shall review the hospital's request and any additional information and decide whether a change in the DRG assignment is appropriate. If the Department decides that a higher-weighted DRG should be assigned, it must request the Definitions peer review organization to review the case to verify the change in DRG assignment.

C) Following the 60-day period described in subsection (a)(4)(A) above, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

b) Illinois Rates for Admission

1) Reimbursement to hospitals for claims for admissions occurring prior to October 1, 1992, shall be calculated and paid in

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accordance with the statutes and administrative rules governing the time period when the services were rendered. The payments described in Sections 149.5 through 149.150 and 89 Ill. Adm. Code 148.250 through 148.300 shall be effective for admissions on and after October 1, 1992, subject to 89 Ill. Adm. Code 148.20(b) and Section 149.5(b).

2) The payments described in 89 Ill. Adm. Code 148.82 shall be effective for services provided on or after July 1, 1992.

c) Determining Prospective Payment Rates

1) Federal/Regional Blended Rate Per Discharge

A) Except as specified in subsection (c)(1)(B) below, the Department shall reimburse hospitals for inpatient services at the federal/regional blended rate per discharge for the Medicare Program, which includes the hospital-specific portion as described in subsection (c)(2) below, if applicable, and as computed by the PPS Pricer, as described in Section 149.5(c)(3).

B) In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), on July 15, 1993:

i) Effective with admissions occurring on October 1, 1993, and for the duration of the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the Department shall recompute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect on September 1, 1992, under the Medicare Program.

ii) Effective with admissions occurring on or after the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall compute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect 90 days prior to the date of admission, under the Medicare Program.

2) Hospital-Specific Portion

The hospital-specific portion is defined as the specific status and any applicable add-ons under the Medicare Program in recognition of sole community hospitals, rural referral centers and Medicare dependent hospitals, and rural hospitals deemed urban.

3) DRG PPS Base Rate

The DRG PPS base rate shall be defined as the sum of the amounts computed under subsections (c)(1) and (c)(2), multiplied by the Illinois weighting factor assigned to the DRG into which the case

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has been classified.

4) Payment Adjustments
In addition to the DRG PPS base rate defined in subsection (c)(3), hospitals shall receive applicable outlier adjustments, in accordance with Section 149.105; applicable adjustments for ~~resident care education payments, in accordance with Section 149.140; applicable adjustments for indirect medical education costs, capital costs, direct medical education costs, and CRNA costs~~ in accordance with Section 149.150(c); applicable adjustments for disproportionate share, in accordance with 89 Ill. Adm. Code 148.120; applicable adjustments for uncompensated care, in accordance with 89 Ill. Adm. Code 148.150; various specific inpatient payment adjustments, as applicable, in accordance with 89 Ill. Adm. Code 148.290; and, on a retrospective basis, ~~any applicable adjustment for kidney acquisition costs in accordance with Section 149.150(c)(5)~~.

d) Application of Upper Payment Limits. The Department shall adjust each of the prospective payment rates determined under subsection (c) above (with the exception of disproportionate share payment adjustments made in accordance with 89 Ill. Adm. Code 148.120) to ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42 CFR 447.272, Application of Upper Payment Limits.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 149.105 Payment For Outlier Cases

a) General Provisions
1) Except as provided in subsections (a)(3) and (a)(4) of this Section, the Department provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by the Department, to a hospital for covered inpatient hospital services furnished to a Medicaid client, if either of the conditions in the following subsections (A) or (B) apply. The client's length of stay (including up to three administrative days) exceeds the day outlier threshold, determined by the Department, for the appropriate applicable DRG.
A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the threshold is set at the lesser of the geometric mean length of stay plus 24 days, or the geometric mean length of stay plus three standard deviations.
B) For rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the geometric mean length of stay plus the lesser of three standard deviations, or the Medicare day outlier cutoff threshold in effect 90 days prior to the date of admission, adjusted by a

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factor, the numerator of which is the Medicaid geometric length of stay, and the denominator of which is the average Medicare geometric mean length of stay.

2) The hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as described in subsection (c)(3) of this Section, exceed the greater of:
A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), 34,000 as adjusted for the hospital's labor market, or the hospital's DRG PPS base rate as described in Section 149.100(c)(1) multiplied by two.
B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall utilize the Medicare established cost outlier cutoff threshold in effect 90 days prior to the date of admission. ~~The Medicare outlier threshold shall be adjusted by a factor, the numerator of which is the Medicaid geometric length of stay, and the denominator of which is the Medicare geometric mean length of stay.~~

3) The Department will provide cost outlier payments to a transferring hospital reimbursed under the DRG PPS that does not receive payment under subsection (b) of this Section for discharges specified in Section 149.25(b)(4)(B), if the hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as described in subsection (c)(3), exceed:
A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), the greater of the criteria specified in subsection (a)(2)(A) of this Section.
B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the criteria specified in subsection (a)(2)(B) of this Section.

4) The Department will not provide outlier payments for:
A) Discharges classified as psychiatric care (DRGs 424-432). Such care provided by other than hospitals or distinct part units enrolled with the Department to provide psychiatric care (category of service 21) is limited to emergency treatment, to last no longer than three days.
B) Discharges assigned to DRGs with an Illinois weighting factor of zero (0.0000).

5) The Department or its designee may review outlier cases on a prepayment or postpayment review basis. The charges for any services identified as noncovered through this review will be denied and any outlier payment having been made for those services will be recovered, as appropriate, after a determination as to the provider's liability has been made. If the Department or its designee finds a pattern of inappropriate utilization by a hospital, all outlier cases from that hospital are subject to

medical review, and this review may be conducted prior to payment until the Department or its designee determines that appropriate corrective actions nave been taken. The Department, or its designee, must review and approve, to the extent required by the Department:

A) The admission was medically necessary and appropriate.

B) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay.

C) The services were ordered by the physician, actually furnished, and non duplicatively billed.

D) The validity of the diagnostic and procedural coding.

E) The granting of up to three administrative (grace) days during which the hospital is seeking an appropriate setting into which to discharge a non acute patient.

b) Payment for Extended Length-of-Stay Cases (Day Outliers)

1) If the hospital stay includes covered days of care beyond the applicable threshold criterion, the Department will make an additional payment, on a per diem basis, to the discharging hospital for those days and the transferring hospital for DRG 385, 456, or 985 only. A special request or submission is not necessary to initiate this payment.

2) Except as provided in subsection (d) of this Section, and subject to the limitations described in subsection (e) of this Section, the per diem payment made under subsection (b)(1) is derived by first taking ~~60 percent~~ the marginal cost factor, as defined in Section 148.5(c)(4), of the per diem payment for the applicable DRG, as calculated by dividing the DRG PPS base rate, determined under Section 149.100(c)(3), by the mean length-of-stay for that DRG.

3) Any days in a covered stay identified as noncovered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.

c) Payments for Extraordinarily High Costs Cases (Cost Outliers)

1) If the hospital charges, as adjusted by the method specified in subsection (c)(3) exceed the applicable threshold criterion, the Department will make an additional payment to the hospital to cover those costs. A special request or submission is not necessary to initiate this payment.

2) The Department will reimburse the cost of the discharge on the billed charges for covered inpatient services, adjusted by a cost-to-charge ratio as described in subsection (c)(3), subject to the limitations described in subsections (c)(4) and (e) of this Section.

3) The cost-to-charge ratio used to adjust covered charges is computed at the beginning of each rate period, as described in 89 Ill. Adm. Code 148.25(g)(2), by the Department for each hospital based on the hospital's base fiscal year. Statewide

cost-to-charge ratios are used in those instances in which a hospital's cost-to-charge ratio falls outside reasonable parameters or cannot be computed due to a lack of information (e.g., a new hospital for which the Department is not in possession of the required historical information).

4) If any of the services are determined to be noncovered, the charges for those services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

5) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), the Department shall employ the same methodologies and rates used by Medicare, to calculate additional payments for cost outliers. ~~Except as provided in subsection (c)(6), the additional amount is 75 percent of the difference between the hospital's adjusted cost for the discharge as determined under subsection (c)(3) and the threshold criteria established under subsection (a)(1)(A)(ii), subject to the limitations described in subsections (c)(4) and (e) of this Section.~~

~~6) The additional payment amount for burn cases (DRGs 456-460) is computed under the provisions of subsection (c)(5), except that the payment is 90 percent of the difference between the hospital's adjusted cost for the discharge and the threshold criteria.~~

d) Payment for Extraordinary High Cost Day Outliers. If a discharge qualifies for an additional payment under the provisions of both subsections (b) and (c), the additional payment is, subject to the limitations described in subsection (e) of this Section, the greater of the following:

1) The payment computed under subsection (b) above.

2) The payment computed under subsection (c) above.

e) Outlier Payment Limitation. Notwithstanding any other provisions of this Section, the total reimbursement paid by the Department, excluding payments described in 89 Ill. Adm. Code 148.120, for a claim qualifying for an outlier payment under this Section shall not exceed the total covered inpatient charges.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 149.125 Special Treatment of Certain Facilities

a) General Rules

1) Sole Community Hospitals. Hospitals defined as sole community hospitals shall, under subsection (b) below, shall have the choice of being reimbursed under the DRG PPS methodology, as described in Sections 149.5 through 149.150, or the Definitions Alternate Reimbursement methodology as described in Sections

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148.250 through 148.300, in accordance with the provisions of 89 Ill. Adm. Code 148.40(f) through (h).

2) Hospitals that Serve a Disproportionate Share of Low Income Patients. The Department shall make additional payments to hospitals that serve a disproportionate share of low income patients. The criteria and methodologies for such additional payments are set forth in 89 Ill. Adm. Code 148.120.

3) ~~Uncompensated Care Adjustments. The Department shall make an additional payment to hospitals that provide equal access to low income persons. The criteria and methodology for this additional payment are set forth in 89 Ill. Adm. Code 148.159.~~

4) Specific Inpatient Payment Adjustments. The Department shall make specific additional payments to applicable hospitals as set forth in 89 Ill. Adm. Code 148.290.

b) Criteria for Classification as a Sole Community Hospital. "Medicaid Sole Community Provider" means a nospital that meets one of the following criteria:

1) Medicare Program Designation

A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective September 1, 1992.

B) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(B), any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare program effective 90 days prior to the date of admission.

2) Primary Service Area Designation

A) Any rural hospital, as described in 89 Ill. Adm. Code 148.25(g)(3), that serves 55 percent or more of the Medicaid patients residing within the hospital's primary service area for the provision of inpatient hospital services.

B) "Primary service area" means the geographic area defined by U.S. Postal Service Zip Codes in which 50 percent or more of a hospital's inpatients reside.

C) The determination of sole community provider status under this subsection (b) shall be made prior to the rate period, as described in 89 Ill. Adm. Code 148.25(g)(2).

D) The data used to make this determination will be from the Illinois Health Care Cost Containment Council (IHCCCC) for the most recent four quarters for which information is available.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 149.140 Methodology for Determining Primary Care Access Health Care Education Payments (Repealed)

~~a) Payments will be made to qualifying teaching hospitals for the purpose of encouraging medical schools and affiliated teaching hospitals to increase the number and to promote the education of primary health care professionals and the placement of those professionals in areas of the State that suffer a shortage of medical professionals.~~

~~b) Definitions.~~

~~1) "Full time equivalent countable resident" means a resident that meets both of the following criteria:~~

~~A) A resident that is, as defined by the federal Department of Health and Human Services, allowed to be reported on the Medicare Cost Report when calculating Graduate Medical Education (GME) payments, as of October 1, 1993, and as of the first day of any Medicare rate year subsequent to the rate period in effect as of April 1, 1994.~~

~~B) A resident that is, as of October 1, 1993, and as of the first day of any Medicare rate year subsequent to the rate period in effect as of April 1, 1994, in the first, second, third or fourth year of their first residency training program.~~

~~2) "Full time equivalent resident" means, for the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A) and for the first subsequent rate period as described in 89 Ill. Adm. Code 148.25(g)(2)(B), residents, as defined by the federal Department of Health and Human Services, and allowed to be reported on the Medicare cost report on file with the Department for the latest cost report period ending between 9 and 30 months prior to the beginning of the fiscal year in which the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A) begins.~~

~~3) "Full time equivalent qualified rotation" means one full time equivalent countable resident that works full time, or its proportional equivalent, in any qualified setting.~~

~~4) "Full time equivalent rotation" means one full time equivalent countable resident that works full time, or its proportional equivalent, in any residency location.~~

~~5) "Major academic hospital" means:~~

~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), a hospital located in the State of Illinois, with at least 350 acute care, inpatient beds and at least 300 full time equivalent residents. The source of this information will be the most recent available American Hospital Association Guide.~~

~~B) For subsequent rate periods not described in subsection (b)(5)(A) above, a hospital, located in the State of Illinois, with at least 350 acute care, inpatient beds and at least 300 full time equivalent residents. The source of~~

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this information will be the most current Illinois Department of Public Health published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois", which is available to the Department sixty days preceding a rate period, as described in 89 Ill. Adm. Code 148.25(g)(2)(B) that is not described in subsection (b)(5)(A) above. Inpatient beds shall include total beds, excluding any used for substance abuse, long term care or swing beds. The source of information on full time equivalent residents will be the most recent available Medicare Cost Report.

6) "Primary care clinic" means any hospital sponsored or affiliated practice site in which at least 50 per centum of patient visits to the clinic are for primary care, or meets one or more of the following criteria:

A) At least 50 per centum of all staff physicians (including salaried, contractual, and part time) routinely provide obstetric, pediatric, internal medicine, or family practice care in the clinic setting.

B) The clinic enrolls in the Healthy Moms/Healthy Kids program and meets the following criteria:

i) The clinic accepts 1,000 or more pregnant women for obstetrical care through the Healthy Moms/Healthy Kids program between July 1, 1993, and June 30, 1994.

ii) The clinic accepts 1,250 or more pregnant women for obstetrical care through the Healthy Moms/Healthy Kids program between July 1, 1994, and June 30, 1995.

iii) The clinic accepts 1,500 or more pregnant women for obstetrical care through the Healthy Moms/Healthy Kids program between July 1, 1995, and June 30, 1996, and each year thereafter.

C) The clinic enrolls in the Healthy Moms/Healthy Kids program and meets the following criteria:

i) The clinic accepts 3,000 or more women and children for primary care services through the Healthy Moms/Healthy Kids program between July 1, 1993, and June 30, 1994.

ii) The clinic accepts 3,750 or more women and children for primary care services through the Healthy Moms/Healthy Kids program between July 1, 1994, and June 30, 1995.

iii) The clinic accepts 4,500 or more women and children for primary care services through the Healthy Moms/Healthy Kids program between July 1, 1995, and June 30, 1996, and each year thereafter.

7) A primary care clinic does not include clinics or facilities established for emergency room usage.

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8) "Qualified rotation setting" means any of the following:

A) A clinic that meets one of the following criteria:

i) A primary care clinic that has 20 per centum or more of its annual patients eligible for medical assistance.

ii) A primary care clinic that has 25,000 or more of its annual patient visits eligible for medical assistance.

iii) A primary care clinic that has 5,000 or more of its annual patient visits eligible for medical assistance and 10 per centum or more increase in its annual patients eligible for medical assistance from one year to the next.

B) A federally qualified health center.

C) A rural health center.

9) "Qualified rotation ratio" means the ratio of the total full time equivalent qualified rotation to the total full time equivalent rotation of all countable residents.

10) "Medicare rate year" means any Medicare rate year in effect as defined by the federal Health Care Finance Administration (HCFA).

c) Initiative Goals. The goals of this initiative are to direct State resources into incentives that will:

1) Increase the number of primary health care professionals trained in community primary care settings.

2) Increase the number of primary health care professionals providing thorough medical services to persons eligible for medical assistance.

3) Decrease the number of non urgent hospital emergency room visits.

4) Promote cooperation among medical schools, major teaching hospitals, and primary care providers to develop programs that will:

A) Encourage medical students to select primary care specialities.

B) Establish and staff clinics that are located in medically underserved areas or underserved Medicaid areas.

C) Promote the use of preventive care.

d) Participation Requirements.

1) Major academic hospitals must enroll with the Department to participate in the initiative.

2) Hospitals receiving payments under this initiative are to use these payments for the establishment of new programs or the enhancement of existing programs that will achieve the goals described in subsection (c) above.

3) Hospitals receiving payments under this incentive must comply with reporting requirements as described in subsection (f) be-

e) Payment methodology. For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), payments will be made as an add on for any DRG PPS discharge from a participating hospital. The amount of that payment shall be a per discharge amount which will be the quotient of

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the hospital-specific-incentive-level-divided-by-the-number-of-DRG-PPS discharges--expected,--by--the--Department,--to--occur-during-the-rate period-described-in-89-Ill.-Adm.-Code-148.25(g)(2)(A).--For--the--rate periods--described--in--89--Ill.--Adm.--Code--148.25(g)(2)(B),-payment adjustments--will--be--made--for--any--DRG--PPS---discharge---from---a participating--hospital;-however,-the-amount-of-the-payment-adjustment shall-be-a--per--diem--amount--which--will--be--the--quotient--of--the hospital-specific--incentive--level--divided--by-the-number-of-DRG-PPS inpatient-days-expected,--by--the--Department,--to--occur--during--the applicable---rate---period,---as---described--in--89--Ill.--Adm.--Code 148.25(g)(2)(A).---The--hospital-specific--incentive--level--shall--be determined-as-follows:

1) For--the--rate--period---described---in---89---Ill.---Adm.---Code 148.25(g)(2)(A),---and---for--the--first--subsequent--rate--period described---in---89---Ill.---Adm.---Code---148.25(g)(2)(B),---the hospital-specific-incentive-level-shall-be--the--product--of--the annual--resident-funding-factor,-which-for-rate-periods-beginning on-or-after-October-1,-1992,-shall-be-$7,500,-and-the--number--of countable-residents,-which-is-the-lesser-of:

A) The-total-number-of-full-time-equivalent-residents.

B) Sixty-per-centum-of-the-number-of-acute-care-inpatient-beds.

2) For--subsequent--rate--periods-not-described-in-subsection-(e)(1) above,-the-hospital-specific-incentive-level-shall-be-the-product of-the-following-2-factors:

A) The-annual-resident-funding-factor,-which-shall-be-$8,500.

B) The-lesser-of:

i) The-total-number--of--full-time--equivalent--countable residents.

ii) Sixty-per-centum-of-the-number-of-acute-care-inpatient beds,--as--determined--in--accordance--with-subsection (b)(5)(B)-of-this-Section.

C) The-quotient-of-the-qualified-rotation-ratio-divided-by--the Department's-qualified-rotation-goal.

3) The-Department's-qualified-rotation-goals-are-as-follows:

A) Three--per-centum-of-the-total-full-time-equivalent-rotation time-from-October-1,-1993,-through--the--day--prior--to--any Medicare--rate--year,--as--described--in--subsection-(b)(10) above,-in-effect-as-of-April-1,-1994.

B) Four-per-centum-of-the-total-full-time--equivalent--rotation time-of-the-Medicare-rate-year-beginning-on-or-after-January 1,-1995.

C) Six--per--centum--of-the-total-full-time-equivalent-rotation time-of-the-Medicare-rate-year-beginning-on-or-after-January 1,-1996.

D) Nine-per-centum-of-the-total-full-time--equivalent--rotation time-of-the-Medicare-rate-year-beginning-on-or-after-January 1,-1997.

E) Twelve-per-centum-of-the-total-full-time-equivalent-rotation time-of-the-Medicare-rate-year-beginning-on-or-after-January 1,-1998.

4) Payments--for--rotation--goals-shall-begin-with-the-Medicaid-rate year-that-begins-subsequent-to-the-conclusion-of-a-rotation-goal.

5) Thirty-days-prior-to-the-beginning-of-each-rate-period,-hospitals receiving-payments-under-this-Section-must-provide-the-Department with-data-necessary-to-determine--total--rotation--time--and--the rotation--time--in--qualified--settings--for--the-months-within-a rotation-goal.

6) Payment--Adjustment--Cap.---The--aggregate--payments--under--this Section--shall--be--capped--at--$17,000,000--per---rate---period. Reimbursement--to--each--hospital--receiving--payments-under-this Section-shall-also-be-capped-at-125-per-centum-of-the-product--of countable--residents--multiplied--by--the-annual-resident-funding factor.--If-aggregate-payments-exceed--$17,000,000,--payments--to each--participating--major--academic-hospital-will-be-adjusted-in proportion-to-not-exceed-the-total-payments--under--this--Section for-the-rate-period.

7) Appeal--Process.--Hospitals-receiving-payments-under-this-Section may-appeal-the-amount-of-their-payments--in--accordance--with--89 Ill.-Adm.-Code-148.310(a)(3).

f) Reporting--requirements.---Participating--hospitals--must--provide-the Department-with--data--and--other--information--the--Department--deems necessary--to--determine-eligibility-for-participation,-and-to-monitor and-evaluate-this-initiative.--This-information-may-include,--but--not be-limited-to:

1) The-names-and-program-year-of-individual-residents.

2) Data-maintained-for-residency-review-committees.

3) Quarterly--data--necessary--to-determine-the-actual-percentage-of countable-resident-time-spent-in-qualified-rotation-settings.

4) Quarterly-data-necessary-to-determine-if-certain-facilities--meet the-defined-requirements-of-a-qualified-rotation-setting.

(Source: Repealed at 19 Ill. Reg. _____, effective _____)

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Section 149.150 Payments to Hospitals Under the DRG Prospective Payment System

a) Total Medicaid Payment. Under the DRG PPS, the total payment for inpatient hospital services furnished to a Medicaid client by a hospital will equal the sum of the payments listed in subsections (b) through (c). In addition to the payments listed in subsections (b) through (c) of this Section, hospitals shall also receive disproportionate share adjustments in accordance with 89 Ill. Adm. Code 148.120, if applicable, uncompensated care adjustments in accordance with 89 Ill. Adm. Code 148.150, if applicable, and various specific inpatient payment adjustments in accordance with 89 Ill. Adm. Code 148.290, if applicable.

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b) Payments Determined on a Per Case Basis. A hospital will be paid on a per case basis (with the exception of kidney acquisition costs) the following amounts:
   1) the appropriate DRG PPS rate for each discharge as determined in accordance with Section 148.100(c).
   2) The appropriate outlier payment amounts determined under Section 149.105.
   3) Capital related costs as determined under subsection (c)(1)(A) below.
   ~~4) Direct medical education costs as determined under subsection (c)(2)(A) below.~~
   ~~5) Indirect medical education costs as determined under subsection (c)(3) below.~~
   ~~6) Anesthesia services of hospital employed non physician anesthetists (Certified Registered Nurse Anethetists or "CRNAs") as set forth in Section 6132(a) of the Omnibus Budget Reconciliation Act of 1989 and in accordance with subsection (c)(4)(A).~~
   ~~7) Kidney acquisition costs in accordance with subsection (c)(5).~~
   ~~8) Primary care access health care education payments, if applicable, in accordance with Section 149.140.~~

c) Payments for Capital~~, Direct Medical Education, Indirect Medical Education, CRNA, and Kidney Acquisition~~ Costs. For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A) these costs shall be paid on a per case basis~~, with the exception of kidney acquisition costs~~. For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), these costs shall be paid on a per diem basis~~, with the exception of kidney acquisition costs~~. Payments for these costs shall be calculated as follows:
   1) Capital Related Costs
      A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A):
         i) The capital related costs per diem shall be calculated by taking the hospital's total capital related costs as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in 89 Ill. Adm. Code 148.25(g)(1), divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies (DRI).
         ii) These two trended capital related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.
         iii) The adjusted capital related cost per diem amount, as calculated in subsection (c)(1)(A)(ii) above, shall be rank ordered for all hospitals and capped at the 80th percentile.

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         iv) Each hospital shall receive a per case add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.
      B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B):
         i) Capital related cost per diem shall be calculated in accordance with subsections (c)(1)(A)(i) through (c)(1)(A)(iii) above.
         ii) Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(A)(ii) or subsection (c)(1)(A)(iii) above, whichever is less.
   ~~2) Direct Medical Education Costs~~
      ~~A) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A):~~
         ~~i) The direct medical education cost per diem shall be calculated by taking the hospital's inpatient direct medical education costs as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in 89 Ill. Adm. Code 148.25(g)(1), divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies (DRI).~~
         ~~ii) These two trended direct medical education costs per diems are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.~~
         ~~iii) The adjusted direct medical education cost per diem amount, as calculated in subsection (c)(2)(A)(ii) above, shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.~~
         ~~iv) Each hospital shall receive a per case add on for direct medical education costs which shall be equal to the amount calculated in subsection (c)(2)(A)(ii) or subsection (c)(2)(A)(iii) above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.~~
      ~~B) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B):~~
         ~~i) Effective with rate periods beginning on or after April 1, 1994, hospitals will be separated into two peer groups for the purpose of computing direct medical education cost per diems.~~

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ii) For the purpose of computing the direct medical education cost per diems, all hospitals described in Ill. Adm. Code 148.25(d) shall be defined as major teaching hospitals. All other hospitals reporting direct medical education costs shall be defined as other teaching hospitals.

iii) Effective with rate periods beginning on or after April 1, 1994, the adjusted direct medical education cost per diem for all hospitals in each peer group shall be calculated by utilizing the direct medical education cost per diems for each hospital that were in effect on June 30, 1993, under the methodology described in subsections (c)(2)(A)(i) and (c)(2)(A)(ii) of this Section.

iv) The adjusted direct medical education cost per diem, as described in subsection (c)(2)(B)(iii) above, shall be rank ordered for all hospitals reporting such costs within each peer group, and capped at the 80th percentile.

v) Each hospital shall receive a per diem add on for direct medical education costs which shall be equal to the amount calculated in subsection (c)(2)(B)(iii) or subsection (c)(2)(B)(iv) above, whichever is less.

3) Determination of Indirect Medical Education (IME) Adjustment Factor. To determine the indirect medical education (IME) factor, the Department shall:

A) With respect to the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), use the indirect medical education factors, as determined by HCFA, in effect on September 1, 1992. This factor shall be multiplied by the sum of the result of the calculation described in Section 149.100(c)(3) plus any applicable outlier payments as described in Section 149.105.

B) With respect to the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), use the indirect medical education factors, determined by the HCFA, in effect 90 days prior to the date of admission. This factor shall be multiplied by the sum of the result of the calculation described in Section 149.100(c)(3), plus any applicable outlier payments as described in Section 149.105.

4) CRNA Costs

A) Only hospitals that qualify for these payments under the Medicare Program effective at the beginning of each rate period, as described in 89 Ill. Adm. Code 148.25(g)(2), shall be eligible for these payments.

B) The CRNA cost per case amount shall be calculated by taking the hospital's total CRNA costs (as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in 89 Ill. Adm. Code 148.25(g)(1), divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies (BRI).

C) Each qualifying hospital, as described in subsection (c)(4)(A) above, shall:

i) For the rate period described in 89 Ill. Adm. Code 148.25(g)(2)(A), receive a per case add on for CRNA costs which shall be equal to the amount calculated under subsection (c)(4)(B) above, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.

ii) For the rate periods described in 89 Ill. Adm. Code 148.25(g)(2)(B), receive a per diem add on for CRNA costs which shall be equal to the amount calculated under subsection (c)(4)(B) above.

5) Kidney Acquisition Costs. Kidney Acquisition Costs shall be reimbursed on a retrospective basis. The reimbursement shall be calculated by multiplying the hospital's total charges for the kidney acquisition by the hospital's cost to charge ratio as described in Section 149.105(c)(3).

6)2) A hospital wishing to appeal the calculation of its rates must notify the Department within 30 days after receipt of the rate change notification.

d) Method of Payment

1) General Rule. Unless the provisions of subsection (d)(2) apply, hospitals are paid for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an excluded distinct part psychiatric or a rehabilitation unit of a hospital are made in accordance with 89 Ill. Adm. Code 148.270(b).

2) Special Interim Payment for Unusually Long Lengths of Stay

A) First Interim Payment. A hospital may request an interim payment after a Medicaid client has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

B) Additional Interim Payments. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under subsection (d)(2)(A). Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of subsection (d)(2).

3) Outlier Payments. Except as provided in subsection (d)(2),

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payment for outlier cases (described in Section 149.105) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.

e) Reductions to Total Payments

1) Copayments. Copayments are assessed under all medical programs administered by the Department and shall be assessed in accordance with 89 Ill. Adm. Code 148.190.

2) Third Party Payments. Hospitals shall determine that services rendered are not covered, in whole or in part, under any other state or federal medical care program or under any other private group indemnification or insurance program, health maintenance organization, preferred provider organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Definitions payment obligation shall be reduced.

f) Effect of Change of Ownership on Payments Under the DRG Prospective Payment System. When a hospital's ownership changes, the following rule applies: Payment for the cost of inpatient hospital services for each patient, including outlier payments, as provided under subsection (b) above, will be made to the entity that is the legal owner on the date of discharge. Payments will not be prorated between the buyer and seller.

1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a Medicaid client regardless of when the client's coverage began or ended during a stay, or of how long the stay lasted.

2) Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of the information is attributable to a period during which a different party legally owned the hospital.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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1) Heading of the Part: Hospital Services

2) Code Citation: 89 Ill. Adm. Code 148

3) Section Numbers: Proposed Action:

148.25, 148.40, 148.120,	Amendment
148.130, 148.140, 148.150,	Amendment
148.160, 148.170, 148.250,	Amendment
148.260, 148.270, 148.290,	Amendment
148.310	Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, par. 12-13) [305 ILCS 5/12-13]

5) Complete Description of the Subjects and Issues Involved: Amendments are being proposed to the Department's rules concerning Hospital Services. Some of the proposed changes correspond to emergency rulemakings in Sections 148.25 and 148.120, effective March 1, 1995, which provide that State owned facilities operated by the Department of Mental Health and Developmental Disabilities (DMHDD) shall be eligible for disproportionate share (DSH) hospital adjustments. The Department is initiating this action to maximize federal financing benefits to hospitals as permitted by Illinois' federal DSH spending limitations. The DSH payments for DMHDD operated facilities shall be in addition to the reimbursements currently paid for services provided by these facilities. The DSH payment amount made to each facility will be determined according to a methodology consistent with current DSH formulas and include mechanisms to ensure compliance with OBRA'93 guidelines and federal DSH spending limitations.

In addition, the proposed amendments also bring the Department into compliance with federal statutory requirements regarding disproportionate share adjustments, and with provisions of Public Act 88-554 concerning the elimination of certain adjustment payments.

Section 148.170 contains reimbursement methodology for hospitals organized under the University of Illinois Hospital Act. In order to meet federal regulations set forth in Public Law 103-66, the Department is proposing changes to the reimbursement methodology for hospitals organized under the University of Illinois Hospital Act.

Proposed amendments throughout these rules are necessary to comply with provisions of Public Act 88-554. Therefore, adjustment payments for health care education, outpatient indigent volume, uncompensated care, trauma care, perinatal care, obstetrical are, targeted access, and Medicaid high volume for non-disproportionate share hospitals shall be eliminated. Additionally, technical changes are being proposed throughout these rules.

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It is anticipated that these proposed amendments will result in a reduction in Department expenditures of approximately $391.7 million for Fiscal Year 1996.

6) Will these proposed amendments replace emergency amendments currently in effect? Some of the proposed amendments in Sections 148.25 and 148.120 will replace emergency amendments which were effective March 1, 1995, and are to be published on March 17, 1995. The proposed amendments which will replace emergency amendments pertain to facilities operated by the Department of Mental Health and Developmental Disabilities and their eligibility for receiving disproportionate share payment adjustments. These changes are fully described above in the complete description of the subjects and issues involved.

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: These proposed amendments do not affect units of local government.

11) Time, Place, and Manner in which Interested Persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to Joanne Jones, Bureau of Rules and Regulations, Illinois Department of Public Aid, 100 South Grand Ave. E., 3rd Floor, Springfield, Illinois 62762 (Phone: (217) 524-3215). The Department requests the submission of written comments within 30 days after the publication of this notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

Any interested persons may review these amendments at the Department of Public Aid's local offices located in each county (except Cook County). In Cook County, the amendments may be reviewed at the Office of the Director, Illinois Department of Public Aid, 310 South Michigan Avenue, Suite 1700, Chicago, Illinois. The amendments may be reviewed at all offices Monday through Friday from 8:30 A.M. until 5:00 P.M. These copies of the amendments are being made available for review in accordance with federal requirements at 42 CFR 447.205.

These proposed amendments may have an impact on small businesses, small municipalities, and not for profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory

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flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not for profit corporations as part of any written comments they submit to the Department.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Hospitals

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) State reasons for this rulemaking if it was not included in either of the two most recent regulatory agendas: The reasons for this rulemaking are fully described above in the complete description of the subjects and issues involved. This rulemaking was inadvertantly omitted when the two most recent regulatory agendas were published.

The full text of the Proposed Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

Section
148.10 Hospital Services
148.20 Participation
148.25 Definitions and Applicability
148.30 General Requirements
148.40 Special Requirements
148.50 Covered Hospital Services
148.60 Services Not Covered as Hospital Services
148.70 Limitation On Hospital Services
148.80 Organ Transplants Services Covered Under Medicaid (Repealed)
148.82 Organ Transplant Services
148.90 Heart Transplants (Repealed)
148.100 Liver Transplants (Repealed)
148.110 Bone Marrow Transplants (Repealed)
148.120 Disproportionate Share Hospital (DSH) Adjustments
148.130 Outlier Adjustments for Exceptionally Costly Stays
148.140 Hospital Outpatient and Clinic Services
148.150 Public Law 103-66 Requirements ~~Uncompensated Care Payment Adjustments~~
148.160 Payment Methodology for County-Owned Hospitals in a County with a Population of Over Three ~~3~~ Million
148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act
148.180 Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting
148.190 Copayments
148.200 Alternate Reimbursement Systems
148.210 Filing Cost Reports
148.220 Pre September 1, 1991 Admissions
148.230 Admissions Occurring on or after September 1, 1991
148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals
148.260 Calculation and Definitions of Inpatient Per Diem Rates
148.270 Determination of Alternate Cost Per Diem Rates for All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals
148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements
148.290 Adjustments and Reductions to Total Payments
148.300 Payment
148.310 Review Procedure

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148.320 Alternatives
148.330 Exemptions
148.340 Subacute Alcoholism and Substance Abuse Treatment Services
148.350 Definitions
148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services
148.368 Volume Adjustment (Repealed)
148.370 Payment for Subacute Alcoholism and Substance Abuse Treatment Services
148.373 Utilization (Repealed)
148.376 Utilization, Case-Mix and Discretionary Funds
148.380 Rate Appeals for Subacute Alcoholism and Substance Abuse Treatment Services
148.390 Hearings
148.400 Special Hospital Reporting Requirements

AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 6503-1 et seq.) [20 ILCS 2215/Art. III] and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13) [305 ILCS 5/Arts. III, IV, V, VI and VII and 12-13].

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg.

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17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. _____, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. _____, effective _____.

Section 148.25 Definitions and Applicability

a) Payment for hospital inpatient, hospital outpatient and hospital clinic services shall be made only to a hospital or a distinct part hospital unit as defined in this Section.

b) The term "hospital" means:

1) For the purpose of hospital inpatient reimbursement, any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which is located in the State and is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act or any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located. In addition, unless specifically indicated otherwise, for the purpose of inpatient reimbursement, the term "hospital" shall also include:

A) County-owned hospitals, ~~shall mean~~ meaning all county-owned hospitals~~,~~ that are located in an Illinois county with a population of over 3 million.

B) A hospital ~~and/or hospitals~~ organized under the University of Illinois Hospital Act.

C) A hospital unit that is adjacent to or on the premises of the hospital and licensed under the Hospital Licensing Act or the University of Illinois Hospital Act.

2) For the purpose of hospital outpatient reimbursement, the term "hospital" shall, in addition to the definition described in subsection (b)(1) above, include an encounter rate hospital. An encounter rate hospital is defined as:

A) An Illinois county-owned hospital located in a county with a population exceeding three ~~3~~ million; ~~or~~

B) A hospital ~~and/or hospitals~~ organized under the University of Illinois Hospital Act~~.~~ ; or

C) A county-operated outpatient facility located in a county with a population exceeding three ~~3~~ million that is also located in the State of Illinois.

3) For the purpose of non hospital-based clinic reimbursement, the term "hospital" shall mean:

A) A county-operated outpatient facility, as described in subsection (b)(2)(D) above; or

B) A Certified Hospital Organized Satellite Clinic, as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and subsection (b)(5)(B) below.

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4) For the purpose of hospital-based clinic reimbursement, the term "hospital" shall mean a hospital-based clinic meeting the provisions of 89 Ill. Adm. Code 140.461(a) and Section 148.40(d).

5) For the purpose of Healthy Moms/Healthy Kids reimbursement, as described in 89 Ill. Adm. Code 140.464 and Section 148.140(d)(6), the term "Healthy Moms/Healthy Kids managed care clinic" shall mean a clinic meeting the requirements of 89 Ill. Adm. Code 140.461(f). The following four categories of Healthy Moms/Healthy Kids managed care clinics are recognized under the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140, Subpart G:

A) Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A);

B) Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B);

C) Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C); and

D) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D).

6) For the purpose of disproportionate share hospital adjustments, the term "hospital" shall, in addition to the definition described in subsection (b)(1) above, include the facilities operated by the Department of Mental Health and Developmental Disabilities which are accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO).

c) For the purpose of hospital inpatient reimbursement, the term "distinct part hospital unit" means a hospital, as defined in subsection (b)(1) above, that meets the following qualification(s):

1) Distinct Part Psychiatric Units. A distinct part psychiatric unit is a hospital, with a functional psychiatric unit, that is enrolled with the Department to provide inpatient psychiatric services (category of service 21).

2) Distinct Part Rehabilitation Units. A distinct part rehabilitation unit is a hospital, with a functional rehabilitation unit, that is enrolled with the Department to provide inpatient rehabilitation services (category of service 22).

d) A major teaching hospital is defined as a hospital having four or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post - doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation. Except, in the case of a hospital devoted exclusively to physical rehabilitation, as defined in 89 Ill. Adm. Code 149.50(c)(2), or in the case of a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), only one certified program is required to be so classified.

e) Except as provided in subsection (d) above, a teaching hospital is

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defined as a hospital having at least one, but no more than three, graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.

f) A non-teaching hospital is defined as:
   1) A hospital that reports teaching costs on the Medicare or Medicaid cost reports but has no graduate medical education programs; or
   2) A hospital that reports no teaching costs on the Medicare or Medicaid cost reports and that has no graduate medical education programs.

g) Definitions. Unless specifically stated otherwise, the definitions of terms used in Sections 148.130, 148.260, 148.270, and 148.280, and in 89 Ill. Adm. Code 149 are as follows:
   1) "Base period" means the two most recent cost report years for which audited cost reports are available for at least 90 percent of cost reporting hospitals.
   2) "Rate period" means:
      A) For admissions, or if applicable, dates of service, on or after October 1, 1992, and on or before March 31, 1994, the eighteen month period beginning on October 1, 1992, and ending on March 31, 1994.
      B) Beginning with admissions, or if applicable, dates of service, on or after April 1, 1994, the period beginning 90 days after the effective date of DRG PPS rates under the federal Medicare Program and ending 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.
   3) "Rural hospital" means a hospital that is:
      A) Located:
         i) Outside a metropolitan statistical area; or
         ii) Located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health.
      B) The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993).
   4) "Urban hospital" means a hospital that is located in a metropolitan statistical area that does not meet the criteria described in subsection (g)(3) above.

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.40 Special Requirements

a) Inpatient Psychiatric Services
   1) Payment for inpatient hospital psychiatric services shall be made only to:
      A) A hospital that is a general hospital, as defined in Section 148.25(b), with a functional unit, as defined in Section 148.25(c)(1), that specializes in, and is enrolled with the Department to provide, psychiatric services; or
      B) A hospital, as defined in Section 148.25(b), that holds a valid license as, and is enrolled with the Department as, a psychiatric hospital, as defined in 89 Ill. Adm. Code 149.50(c)(1).
   2) Inpatient psychiatric services are those services provided to patients who are in need of short-term acute inpatient hospitalization for active treatment of an emotional or mental disorder.
   3) Inpatient psychiatric services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.
   4) Federal Medicaid regulations preclude payment for patients over 20 or under 65 years of age in any Institution for Mental Diseases (IMD). Therefore, psychiatric hospitals may not receive reimbursement for services provided to patients over the age of 20 and under the age of 65. In the case of a patient receiving psychiatric services immediately preceding his/her 21st birthday, reimbursement for psychiatric services shall be provided until the earliest of the following:
      A) The date the patient no longer requires the services; or
      B) The date the patient reaches 22 years of age.
   5) A psychiatric hospital must be accredited by the Joint Commission on the Accreditation of Health Care Organizations to provide services to program participants under 21 years of age or be Medicare certified to provide services to program participants 65 years of age and older. Distinct part psychiatric units and psychiatric hospitals located in the State of Illinois, or within a 100 mile radius of the State of Illinois, must execute an interagency agreement with a DMHDD-operated mental health center (State-operated facilities) for coordination of services including, but not limited to, crisis screening and discharge planning to ensure linkage to aftercare services with private practitioners or community mental health services, as described in subsection (a)(6) below.
   6) Coordination of Care - Purpose. In accordance with subsection (a)(5) above, distinct part psychiatric units and psychiatric

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hospitals located in the State of Illinois, or within a 100 mile radius of the State of Illinois, must execute a Coordination of Care Agreement in order to participate as a provider of inpatient psychiatric services. The Coordination of Care Agreement shall set forth an agreement between the DMHDD-operated mental health center (State-operated facility) and the hospital for the coordination of services, including but not limited to crisis screening and discharge planning to ensure efficient use of inpatient care. The agreement shall also set forth the manner in which linkage to aftercare services with community mental health agencies or private practitioners shall be carried out.

7) Coordination of Care - General Provisions. The general provisions of the Coordination of Care Agreement described in subsection (a)(6) above are as follows:
   A) The hospital shall agree, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations and shall maintain accreditation by JCAHO;
   B) The provider shall comply with Title VI of the Civil Rights Act of 1964 and the Rehabilitation Act of 1973 and regulations promulgated thereunder which prohibit discrimination on the grounds of sex, race, color, national origin or handicap;
   C) The provider shall comply with the following applicable federal, State and local statutes pertaining to equal employment opportunity, affirmative action, and other related requirements: 42 U.S.C.A. 2000e (1981), 29 U.S.C.A. 203 et seq. (1982), Ill. Rev. Stat. 1991, ch. 68, pars. 101 et seq. [775 ILCS 25];
   D) The Coordination of Care Agreement shall remain in effect until amended by mutual consent or cancelled in writing by either party having given thirty (30) days prior notification.
8) Coordination of Care - Special Requirements. The hospital shall:
   A) Provide on its premises the facilities, staff, and programs for the diagnosis, admission, and treatment of persons who may require inpatient care and/or assessment of mental status, mental illness, emotional disability, and other psychiatric problems;
   B) Notify the community mental health agency that serves the geographic area from which the recipient originated to allow the agency to prescreen the case prior to referring the individual to the designated State-operated facility. The community mental health agency's resources and other appropriate community alternatives shall be considered prior to making a referral to the State-operated facility for admission;
   C) Complete any forms necessary and consistent with the Mental Health and Developmental Disabilities Code in the event of a referral for involuntary or judicial admission;
   D) Notify the community mental health agency or private practitioner of the date and time of discharge and invite their participation in the discharge planning process;
   E) Refer to the State-operated facility only those individuals for whom less restrictive alternatives are documented not to be appropriate at the time based on a clinical determination by the community mental health agency, a private practitioner (if applicable), or the hospital; and
   F) Notify the State-operated facility prior to planned transfer of an individual and transfer the individual at such time as to assure arrival of the person prior to 11 a.m. Monday through Friday. In unusual situations, transfers may be made at other times after prior discussion between the hospital and the State-operated facility. The individual will only be transported to the State-operated facility when, based on a clinical determination, he/she is medically stable as determined by the transferring physician. A copy of the transfer summary from the hospital must accompany the recipient at the time of admission to the State-operated facility.
9) Coordination of Care - Special Requirements of the State-Operated Facility. The State-operated facility shall:
   A) Admit individuals who have been screened as defined in the Coordination of Care Agreement and are appropriate for admission consistent with the provisions of the Mental Health and Developmental Disabilities Code.
   B) Evaluate Individuals for whom the hospital has executed a Petition and Certificate for involuntary/judicial admission consistent with the Mental Health and Developmental Disabilities Code.
   C) Consider for admission voluntary individuals for whom less restrictive alternatives are documented not to be appropriate at the time, based on a clinical determination by the community mental health agency, private practitioner (if applicable), the hospital, or the State-operated facility.
10) A participating hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service only on an emergency basis for a maximum period of 72 hours or in cases in which the psychiatric services are secondary to the services for which the period of hospitalization is approved.

b) Inpatient Rehabilitation Services
   1) Payment for inpatient rehabilitation services shall be made only to a general hospital, as defined in Section 148.25(b), with a functional unit of the hospital, as defined in Section

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148.25.(c)(2), which specializes in, and is enrolled with the Department to provide, physical rehabilitation service or a hospital, as defined in 89 Ill. Adm. Code 149.50(c)(2), which holds a valid license as, and is enrolled with the Department as, a physical rehabilitation hospital.

2) The primary reason for hospitalization is to provide a structured program of comprehensive rehabilitation services, furnished by specialists, to the patient with a major handicap for the purpose of habilitating or restoring the person to a realistic maximum level of functioning.

3) Inpatient rehabilitation services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.

4) For payment to be made, a rehabilitation facility, which includes a distinct part unit as described in Section 148.25(c)(2), must be certified by the Health Care Financing Administration for participation under the Medicare Program (Title XIII) and must be licensed and/or certified by the Illinois Department of Public Health to provide comprehensive physical rehabilitation services. Out-of-state hospitals which specialize in physical rehabilitation services must be licensed and/or certified to provide comprehensive physical rehabilitation services by the authorized licensing agency in the state in which the hospital is located.

5) A rehabilitation facility must meet the following criteria:
   A) Have a full-time (at least 35 hours per week) director of rehabilitation; a participating general hospital with a functional rehabilitation unit must have a part-time (at least 20 hours per week) director of rehabilitation;
   B) Have an organized medical staff;
   C) Have available consultants qualified to perform services in appropriate specialties;
   D) Have adequate space and equipment to provide comprehensive diagnostic and treatment services;
   E) Maintain records of diagnosis, treatment progress (notations must be made at regular intervals) and functional results; and
   F) Submit reports as required by the Department of Public Aid.

6) A rehabilitation facility must provide, or have a contractual arrangement with an appropriate entity or agency to provide, the following minimal services:
   A) Full-time nursing services under the supervision of a registered nurse formally trained in rehabilitation nursing;
   B) Full-time physical therapy and occupational therapy services; and
   C) Social casework services as an integral part of the rehabilitation program.

7) A rehabilitation facility must have available the following minimal services:
   A) Psychological evaluation services;
   B) Prosthetic and orthotic services;
   C) Vocational counseling;
   D) Speech therapy;
   E) Clinical laboratory and x-ray services; and
   F) Pharmacy services.

8) The director of rehabilitation must meet the following criteria:
   A) Provide services to the hospital and its patients as specified in subsection (b)(5) above;
   B) Be a doctor of medicine or osteopathy;
   C) Be licensed under State law to practice medicine or surgery; and
   D) Must have, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

9) Personnel of the rehabilitation facility must meet the following minimum standards:
   A) Physicians shall have unlimited licenses to practice medicine and surgery in the state in which they practice. Consultants shall be Board Qualified or Board Certified in their specialty.
   B) Physical therapists shall be licensed by the Illinois Department of Professional Regulation.
   C) Occupational therapists shall be licensed by the Illinois Department of Professional Regulation.
   D) Registered nurses and licensed practical nurses shall be currently licensed by the Illinois Department of Professional Regulation or comparable licensing agency in the State in which the facility is located.
   E) Social workers shall have completed two years of graduate training leading to a Master's Degree in social work from an accredited graduate school of social work.
   F) Psychologists shall have a Master's Degree in clinical psychology.
   G) Vocational counselors shall have a Master's Degree in Rehabilitation Counseling, Psychology or Guidance from a school accredited by the North Central Association or its equivalent.
   H) An orthotist or prosthetist, certified by the American Board of Certification in Orthotics and Prosthetics, shall fabricate or supervise the fabrication of all limbs and braces.

c) End-Stage Renal Disease Treatment (ESRDT) Services. The Department provides payment to hospitals, as defined in Section 148.25(b), for ESRDT services only when the hospital is Medicare certified for ESRDT and services are provided as follows:
   1) Inpatient hospital care is provided for the evaluation and

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treatment of acute renal disease;

2) Outpatient chronic renal dialysis treatments are provided in the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, or a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR Part 405, Subpart U (1994) ~~Subparts--S-and-U-(1984)~~, and the recipient is approved by the Illinois Department of Public Health (IDPH) or the Department of Health and Human Services (DHHS) as eligible for ESRDT services; or

3) Home dialysis treatments are provided through the outpatient renal dialysis department of the hospital, a satellite unit of the hospital that is professionally associated with the center for medical direction and supervision, in a patient's home, or through a free-standing chronic dialysis center certified by Medicare, pursuant to 42 CFR Part 405, Subpart U (1994) ~~Subparts S--and--U--(1984)~~, and the recipient is approved by the Illinois Department of Public Health (IDPH) or the Department of Health and Human Services (DHHS) as eligible for ESRDT services.

c) Hospital-Based Organized Clinic Services. Hospital-based clinics, as described in Section 148.25(b)(4), must meet the requirements of 89 Ill. Adm. Code 140.461(a). The following four categories of hospital-based organized clinic services are recognized in the Medical Assistance Program:

1) General Clinic Services. General clinic services are diagnostic, therapeutic and palliative services provided under the direction of a physician who provides for the health care needs of persons who elect to use this type of service rather than another source of primary care. In order to participate as a provider of general clinic services, a hospital must meet the following requisites:

A) The hospital must be enrolled for participation in the Medical Assistance Program to provide general inpatient (category of service 20) and general outpatient (category of service 24) hospital services.

B) Personnel

i) The clinic must be organized as a distinct hospital department with a qualified, trained executive in charge of all activities and responsible to the administration of the hospital;

ii) An advisory medical council must function to assist the executive officer in formulating policies for the management and care of clinic patients;

iii) The qualifications of the medical staff of the clinic must meet the same requirements that apply to the hospital staff;

iv) Nursing services must be provided by licensed nurses under the supervision of a registered professional nurse (R.N.); and

v) A dietician must be available to instruct the patients regarding special diets and to plan with the patients in the buying and preparation of food.

C) Program

i) The program of the clinic must ensure the provision of comprehensive, high quality, personalized, and continuous health care services to its patients. This means that, at a minimum, the clinic must provide or contract for the services of a sufficient number of primary and specialty care physicians to meet the health needs of patients of the clinic, and must have provisions made for the back-up care of patients when the clinic is not open;

ii) The laboratory, x-ray, and special therapy services must be available for clinic patients, as needed;

iii) The pharmacy must be an integral part of the clinic organization; and

iv) The medical social services in the clinic must be integrated with those in the hospital.

D) Physical Setting and Equipment. The size, location, ventilation, and lighting of accommodations for interviewing, examining, and treating patients and appropriate equipment must be adequate to serve the number and needs of patients accepted by the clinic.

E) Records

i) Clinic records must accurately reflect the patient's condition and contain all significant facts bearing on the case, i.e., history, symptoms and complaints, physical examination findings, laboratory and x-ray procedures, and medications ordered and their results, diagnosis, treatment given or recommended and the patient's response to treatment; and

ii) Clinic records must contain the dates of service and the name of the medical practitioner seeing the patient at the time of each clinic visit.

2) Psychiatric Clinic Services

A) Psychiatric Clinic Services (Type A). Type A psychiatric clinic services are clinic service packages consisting of diagnostic evaluation; individual, group and family therapy; medical control; optional Electroconvulsive Therapy (ECT); and counseling, provided in the hospital clinic setting for individuals through the age of 21.

B) Psychiatric Clinic Services (Type B). Type B psychiatric clinic services are active treatment programs in which the individual patient is participating in no less than social, recreational, and task-oriented activities at least four hours per day at a minimum of three half days of active

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treatment per week. The duration of an individual patient's participation in this treatment program is limited to six months in any twelve month period.

C) Coverage. Psychiatric clinic services are covered for all Medicaid-eligible individuals. The services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.

D) Approval. The Illinois Department of Mental Health and Developmental Disabilities (DMHDD) and the Illinois Department of Public Aid (IDPA) are responsible for approval and enrollment of community hospitals providing psychiatric clinic services. In order to participate as a provider of psychiatric clinic services, a hospital must be enrolled for the provision of inpatient psychiatric services and execute a Psychiatric Clinic Services Type A and B Enrollment Assurance with DMHDD and the Department, which assures that the hospital is enrolled for the provision of inpatient psychiatric services and meets the following requisites:

i) The hospital must be accredited by, and be in good standing with, the Joint Commission on Accreditation of Health Care Organizations (JCAHO);

ii) The hospital must have executed a Coordination of Care Agreement between the hospital and the designated Illinois Department of Mental Health and Developmental Disabilities' State-operated facility serving the mentally ill in the appropriate geographic area;

iii) The clinical staff of the psychiatric clinic must collaborate with the mental health service network to provide discharge, linkage and aftercare planning for recipients of outpatient services;

iv) The hospital must agree to participate in Local Area Networks in compliance with P.L. 99-660 and P.A. 86-844; and

v) The hospital must be enrolled to participate in Medicaid program (Title XIX) and must meet all conditions and requirements set forth by the Illinois Department of Public Aid.

E) Duration of Approval. The approval described in subsection (d)(2)(D) above shall be in effect for a period of two years from the date IDPA approves the psychiatric client's enrollment. The approval may be terminated by IDPA or DMHDD with cause upon 30 days written notice to the hospital. Accordingly, the hospital must submit a 30 day written notification to IDPA and DMHDD when terminating delivery of psycniatric clinic services.

3) Physical Rehabilitation Clinic Services

A) Physical rehabilitation clinic services include the same

rehabilitative services provided to inpatients by hospitals enrolled to provide the services described in Section 148.40(b). Clinic services should be utilized when the patient's condition is such that it does not necessitate inpatient care and adequate care and treatment can be obtained on an outpatient basis through the hospital's specialized clinic.

B) Physical rehabilitation clinic services are not covered for Family and Children Assistance (formerly known as General Assistance) program participants who are 18 years of age or older.

e) Healthy Moms/Healthy Kids Managed Care Clinics. Healthy Moms/Healthy Kids managed care clinics, as described in 89 Ill. Adm. Code 140.461(f) and Section 148.25(b)(5), must meet the requirements of 89 Ill. Adm. Code 140.461(f).

f) Transition to the Diagnosis Related Grouping Prospective Payment System (DRG PPS)

1) Effective with admissions occurring on or after September 1, 1991, and before October 1, 1992, hospitals shall be reimbursed in accordance with the statutes and administrative rules governing the time period when the services were rendered.

2) Effective with admissions occurring on or after October 1, 1992, hospitals that, on August 31, 1991, had a contract in effect with the Department under the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1991, ch. 23, par. 6501-1 et seq.) [320 ILCS 15] and that elected, effective September 1, 1991, to be reimbursed at rates stated in such contracts, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care in accordance with subsection (g) of this Section.

3) In the case of a hospital that was determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b) shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient services during the rate period described in Section 148.25(g)(2)(A):

A) the DRG PPS, as described in 89 Ill. Adm. Code 149, or

B) the rate calculated under Section 148.260.

4) In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in Section 148.25(g)(2)(A), but was subsequently reclassified by the Department as a rural hospital, as described in Section 148.25(g)(3), on July 14, 1993, those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for

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inpatient services provided on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A):

A) the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(c)(1), or

B) the rate calculated under Section 148.260 that would have been in effect for the rate period described in Section 148.25(g)(2)(A) if the hospital had been designated as a sole community hospital on October 1, 1992.

5) For the rate periods described in Section 148.25(g)(2)(B), hospitals, as described in 89 Ill. Adm. Code 149.125(b), shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided during such rate periods described in Section 148.25(g)(2)(B):

A) the DRG PPS, as described in 89 Ill. Adm. Code 149, subject to the provisions of 89 Ill. Adm. Code 149.100(c)(1), or

B) the rate calculated under Section 148.260.

g) Annual Irrevocable Election

1) Hospitals described in subsections (f)(2) and (f)(3) above may elect to be reimbursed under the special arrangements described in subsections (f)(2) and (f)(3) above at the beginning of each rate period.

2) Hospitals described in subsection (f)(4) above may elect to be reimbursed under the special arrangements described in subsection (f)(4) above effective with admissions, or, if applicable, with inpatient services provided, on October 1, 1993, and for the duration of the rate period described in Section 148.25(g)(2)(A).

3) Hospitals described in subsection (f)(5) above may elect to be reimbursed under the special arrangements described in subsection (f)(5) above at the beginning of each rate period described in Section 148.25(g)(2)(B).

4) Once a sole community hospital elects to be reimbursed under the DRG PPS, it may not later in that rate period elect to be classified as exempt. Once a sole community hospital elects to be reimbursed as exempt, it may not later in that rate period elect to be reimbursed under the DRG PPS.

5) Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care. Once such election has been made, the hospital may not later in that rate period year elect to be reimbursed under any other methodology.

6) Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act and have elected to be reimbursed under the DRG PPS may not later elect to be reimbursed at rates stated in such contracts.

h) Notification of Reimbursement Methodology

1) Hospitals shall receive notification from the Department with respect to the reimbursement methodologies that shall be in effect for admissions occurring during the rate period.

2) Hospitals described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) above shall receive notification of their reimbursement options accompanied by a Choice of Reimbursement form. Each hospital described in subsections (f)(2), (f)(3), (f)(4), and (f)(5) above shall have 30 days from the date of such notification to file, with the Department, the reimbursement method of choice for the rate period. In the event the Department has not received the hospital's Choice of Reimbursement form within 30 days from the date of notification, as described above, the hospital will automatically be reimbursed for the rate period under the reimbursement methodology that would have been in effect without benefit of the election described in subsection (g) above.

i) Zero Balance Bills. The Department requires a hospital to submit a bill for any inpatient service provided to an Illinois Medicaid eligible person, including newborns, regardless of payor. A "zero balance bill" is one on which the total "prior payments" are equal to or exceed the Department's liability on the claim. The Department requires that zero balance bills be submitted subsequent to discharge in the same manner as are other bills so that the information can be available for the maintenance of accurate patient profiles and diagnosis-related grouping (DRG) data, and information needed for calculation of disproportionate share and other rates. The provisions of this subsection apply to all hospitals regardless of the reimbursement methodology under which they are reimbursed.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.120 Disproportionate Share Hospital (DSH) Adjustments

Disproportionate Share Hospital (DSH) adjustments for inpatient services provided prior to October 1, 1993, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 1993, and each October 1, thereafter unless otherwise noted.

a) Qualified Disproportionate Share Hospitals (DSH). For inpatient services provided on or after October 1, 1993, the Department shall make adjustment payments to hospitals which are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:

1) The hospital's Medicaid inpatient utilization rate, as defined in subsection (1)(5) of this Section, is at least one half standard deviation above the mean Medicaid utilization rate, as defined in subsection (1)(3) of this Section.

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2) The hospital's low income utilization rate exceeds 25 per centum. For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance), Aid to the Medically Indigent (AMI) and/or any local or state government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for GA and AMI inpatient hospital services, and/or any local or state government-funded care) must be added.

3) Illinois hospitals that, on July 1, 1991, had a Medicaid inpatient utilization rate, as defined in subsection (l)(5) of this Section, that was at least the mean Medicaid inpatient utilization rate, as defined in subsection (l)(3) of this Section, and which were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (42 CFR 5, 1989).

4) Illinois hospitals that:

A) Have a Medicaid inpatient utilization rate, as defined in subsection (l)(5) of this Section, which is at least the mean Medicaid inpatient utilization rate, as defined in subsection (l)(3) of this Section, and

B) Have a Medicaid obstetrical inpatient utilization rate, as defined in subsection (l)(6) of this Section, that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (l)(4) of this Section.

5) Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality shall be considered a children's hospital to the degree that the hospital's medical assistance care is provided to children.

b) In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least 2 obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4), must submit a statement to that effect.

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c) In making the determination described in subsections (a)(1) and (a)(4)(A) above, the Department shall utilize:

1) The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in subsection (l)(5) of this Section, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.

2) In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsections (a)(1) and (a)(4)(A) above. Submittal of a corrected cost report in support of subsections (a)(1) and (a)(4)(A) above must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's Medicaid inpatient utilization rate as described in subsection (l)(5) of this Section.

A) Hospital's Medicaid inpatient utilization rates, as defined in subsection (l)(5) of this Section, which have been derived from unaudited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsection (c)(2) above, hospitals shall have the opportunity to submit corrected cost report information prior to the Department's final DSH determination.

B) In the event a subsequent final audited cost report reflects a Medicaid inpatient utilization rate, as described in subsection (l)(5) of this Section, which is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report utilized for the DSH determination, the Department shall recalculate the Medicaid inpatient utilization rate based upon the final audited cost report, and recoup any overpayments made.

3) Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid Health Maintenance Organization (HMO) days, ~~and--inappropriate--level--of~~ hospital residing long term care days, and Department of Alcohol and Substance Abuse (DASA) Medicaid days. To obtain Medicaid

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utilization levels in these instances, the Department shall utilize:

A) Medicare/Medicaid Crossover Claims.

i) For DSH determination years on or after October 1, 1996, ~~The~~ the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Provider logs as described in the following subsection (c)(3)(A)(ii) will not be used in the determination process for DSH determination years on or after October 1, 1996.

ii) For DSH determination years prior to October 1, 1996, hospitals ~~Hospitals~~ may submit additional information to document Medicare/Medicaid crossover days that ~~which~~ were not billed to the Department due to a determination that the Department had no liability for deductible ~~and~~/or coinsurance amounts. That this information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total number of Medicare/Medicaid crossover days. That this log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days which were not billed to the Department for services provided during the hospital's base fiscal year. If a hospital does not submit a log of Medicare/Medicaid crossover days that meets the above requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.

B) Out-of-state Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.

C) HMO days. The Department will utilize the Department's HMO claims data available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an HMO.

D) Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care inappropriate level of care days provided to recipients.

E) DASA Days. The Department will utilize the Department's DASA paid claims data available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient DASA days provided.

d) Hospitals may apply for DSH status under subsection (a)(2) by submitting an audited certified financial statement for the hospital's base fiscal year. The Department of Mental Health and Developmental Disabilities must submit a statement, signed by the Director of that agency, certifying the accuracy of the data submitted for facilities operated by that agency. The ~~audited certified financial statement~~ statements must contain the following breakdown of information prior to submittal to the Department for consideration:

1) Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

2) Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

3) Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts, except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance, and AMI patients), for the hospital's base fiscal year.

4) Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.

e) With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois, that qualify for DSH in the state in which they are located based upon the Federal definition of a DSH hospital, as defined in Section 1923(b)(1) of the Social Security Act, may qualify for DSH hospital adjustments under this Section. For purposes of determining the Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section and as required in Section 1923(b)(1) of the Social Security Act, out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not qualify by the Medicaid inpatient utilization rate from their state may submit an audited certified financial statement as describe in subsection (d) above. Payments to out-of-state hospitals will be allocated using the same methods as described in subsection (g).

f) Time Limitation Requirements for Additional Information.

1) The information required in subsections (a)(2), (c), (d) and (e) must be received no later than the first day of July preceding

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the DSH determination year for which the hospital is requesting consideration of such information for the determination of DSH qualification. Information required in this Section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

2) The information required in subsection (b) must be received within 30 calendar days after receipt of notification from the Department that the information must be submitted. Information required in this Section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

g) Inpatient Payment Adjustments to DSH. The adjustment payments required by subsection (a) above shall be calculated annually as follows:

1) Five Million Dollar Fund Adjustment for hospitals defined in Section 148.25(b)(1).

A) Hospitals qualifying as DSH hospitals under subsection (a)(1) that have a Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, as described in subsection (1)(3) of this Section, and hospitals qualifying as DSH hospitals under subsection (a)(2) of this Section will receive an add-on payment to their inpatient rate.

B) The distribution method for the add-on payment described in subsection (g)(1)(A) above is based upon a fund of $5 million. All hospitals qualifying under subsection (g)(1)(A) above will receive a $5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by $5. The total dollar amount of this calculation is then subtracted from the $5 million fund.

C) The remaining fund balance is then distributed to the hospitals that qualify under subsection (a)(1) that have a Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, above in proportion to the percentage by which the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the State's Medicaid inpatient utilization rate, as described in subsection (1)(3) of this Section. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid

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value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the $5 million pool of money available after the$5 per day base add-on has been subtracted.

D) The total dollar amount calculated for each qualifying hospital under subsection (g)(1)(C) above, plus the initial$5 per day add-on amount calculated for each qualifying hospital under subsection (g)(1)(B) above, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at per day add-on value. Hospitals qualifying under subsection (a)(2), will receive the minimum adjustment of$5 per inpatient day. The adjustments calculated under this subsection are subject to the limitations described in subsection (k) of this Section.

2) Medicaid Percentage Adjustment for hospitals defined in Section 148.25(b)(1).

A) In addition to the adjustment methodology described in subsection (g)(1) above, all DSH hospitals described in subsection (a)(1), (2), (3) (4), and (5) shall receive a payment adjustment which shall be calculated annually as follows:

B)~~A~~ The payment adjustment shall be calculated based upon the hospital's Medicaid inpatient utilization rate, as defined in subsection (1)(5) of this Section, and subject to subsections (h), (i), and (j) below, as follows:

i) Hospitals with a Medicaid inpatient utilization rate below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25;

ii) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;

iii) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations

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above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $40 plus $7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and

iv) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $90 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate.

C)~~B)~~ For county-owned hospitals, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), the amount calculated pursuant to subsection (g)(2)(B) ~~(g)(2)(A)~~ above shall be increased by $60 per day.

D)~~C)~~ The Medicaid percentage adjustment payment, calculated in accordance with this subsection (g)(2), to a hospital, other than county-owned hospitals, as described in Section 148.25(b)(1)(A), or hospital and/or hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), shall not exceed $155 per day for a children's hospital, as described in subsection (a)(5) of this Section, and shall not exceed $215 per day for all other hospitals.

E)~~D)~~ The amount calculated pursuant to subsections (g)(2)(B) ~~(g)(2)(A)~~ through (g)(2)(D) ~~(g)(2)(C)~~ above shall be adjusted on October 1, 1993, and annually thereafter by a percentage equal to the lesser of:

i) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

ii) The percentage increase in the statewide average hospital payment rate, as described in subsection (1)(8) of this Section, over the previous year's statewide average hospital payment rate.

F)~~E)~~ The amount calculated pursuant to subsections (g)(1) and (g)(2)(B) ~~(g)(2)(A)~~ through (g)(2)(E) ~~(g)(2)(B)~~ above for hospitals described in Section 148.25(b)(1)(A) shall be no less than the DSH rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

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G)~~F)~~ The amount calculated pursuant to subsections (g)(1) and (g)(2)(B) ~~(g)(2)(A)~~ through (g)(2)(E) ~~(g)(2)(B)~~ above, as adjusted pursuant to subsections (h), (i), and (j) below, shall be the inpatient payment adjustment in dollars for the applicable DSH determination year, subject to the limitations described in subsections (g)(2)(D) ~~(g)(2)(C)~~ and (k) of this Section, and the adjustment described in subsection (g)(2)(F) ~~(g)(2)(B)~~ above. The adjustments calculated under subsections (g)(1) and (g)(2)(B) ~~(g)(2)(A)~~ through (g)(2)(F) ~~(g)(2)(B)~~ of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.

3) DMHDD State-Operated Facility Adjustment for hospitals defined in Section 148.25(b)(6). Department of Mental Health and Developmental Disabilities (DMHDD) State-operated facilities qualifying under subsection (a)(2) shall receive an adjustment for inpatient services provided on or after March 1, 1995. The amount of that payment shall be calculated as follows.

A) The amount of the adjustment is based on a State DSH Pool. The State DSH Pool amount shall be calculated by subtracting the estimated DSH payment adjustments made under subsection (g)(1) through (g)(2) above and Sections 148.160(f)(2) and 148.170(f)(2) from the aggregate DSH payment adjustment set by the Health Care Financing Administration (HCFA) in accordance with Public Law 102-234.

B) The State DSH Pool amount is then allocated to hospitals defined in Section 148.25(b)(6) that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of Medicaid inpatient utilization (adjusted based upon historical utilization and projected increases in utilization) to the sum of all qualifying hospitals' Medicaid inpatient utilization.

C) The adjustment calculated in (g)(3)(C) above shall meet the limitation described in subsection (k)(4).

D) The adjustment calculated pursuant to subsection (g)(3)(A) above, for each hospital defined in Section 148.25(b)(6) that qualifies for DSH adjustments, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at a per day adjustment. This amount is subject to the limitations described in subsection (k) of this Section. The adjustment described in this subsection shall be paid on a per diem basis and shall be applied to each Medicaid covered day of care provided.

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h) Inpatient Adjuster for Children's Hospitals. For a children's hospital, as defined in subsection (a)(5) of this Section, the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 2.0.

i) Inpatient Adjustor County-Owned Hospitals. For county-owned hospitals, defined in Section 148.25(b)(1)(A), the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 3.75.

j) Inpatient Adjustor for Hospitals Organized Under the University of Illinois Hospital Act. For a hospital and/or hospitals organized under the University of Illinois Hospital Act, as defined in Section 148.25(b)(1)(B), the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 1.50 ~~3.75~~.

k) DSH Adjustment Limitations.

1) Hospitals that qualify for DSH adjustments under this Section shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues the provision of non-emergency obstetrical care (the provisions of this subsection shall not apply to those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4) or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987). In this instance, the adjustments calculated under subsections (g)(1) and (g)(2) shall cease effective on the date that the hospital discontinued the provision of such non-emergency obstetrical care.

2) Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for DSH payment adjustments based upon the requirements of this Section.

3) DSH Payment Adjustment ~~Cap~~. In accordance with Public Law 102-234, if the aggregate DSH payment adjustments calculated under this Section ~~exceed~~ do not meet the State's final DSH Allotment as determined by the Health Care Financing Administration (HCFA), DSH payment adjustments calculated under this Section shall be adjusted ~~in proportion~~ to meet the ~~lesser~~ State DSH Allotment. This adjustment shall first be applied to DSH payments made under subsection (g)(3) above. If further adjustments are necessary, then DSH payments made under subsection (g)(2) above shall be adjusted, with the DSH payments under subsection (g)(1) being adjusted last.

4) Omnibus Budget Reconciliation Act of 1993 (OBRA'93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospitals' disproportionate share payments shall be made if the sum of Medicaid payments (inpatient, outpatient, and disporportionate share) made to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. The adjustments shall reduce disproportionate share spending until the costs and spending (described in the previous sentence) are equal or until the disproportionate share payments are reduced to zero. In this calculation, persons without insurance costs do not include contractual allowances. Hospitals qualifying for DSH payment adjustments must submit the information required in Section 148.150.

5) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's Medicaid inpatient utilization rate, as defined in subsection (l)(5), is less than one percent.

l) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

1) "Base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993 DSH determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, DSH determination year, etc.

2) "DSH determination year" means the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

3) "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in subsection (c)(3) of this Section. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

4) "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (l)(7) below, provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.), and the denominator

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of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (l)(9) below, for all such hospitals. That information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.

5) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a et seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in subsection (c)(3) of this Section. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

6) "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (l)(7) below, provided by a Medicaid-partcipating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (l)(9) below provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.

7) "Medicaid (Title XIX) obstetrical inpatient days" means hospital inpatient days which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or any ICD-9-CM principal

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diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; ~~within the ranges of 650 and 669 which result in childbirth,~~ and specifically excludes Medicare/Medicaid crossover claims.

8) "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).

9) "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (l)(4) and (l)(6) above, means hospital inpatient days, excluding days for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

10) "Medicaid obstetrical inpatient utilization rate base year" means, for example, state fiscal year 1992 for the October 1, 1993, DSH determination year; state fiscal year 1993 for the October 1, 1994, DSH determination year, etc.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.130 Outlier Adjustments for Exceptionally Costly Stays

a) Outlier Adjustments. Outlier adjustments are provided for exceptionally costly stays provided by hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Section 148.82(g).

b) The determination of those services qualified for an outlier adjustment shall be made as follows for services provided on and after October 1, 1992, and for each subsequent rate period, as defined in Section 148.25(g)(2)(B), for hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Section 148.82(g):

1) The services must have been provided on or after October 1, 1992; and

2) The services must have been provided to:

A) Children who have not attained the age of six years by hospitals defined by the Department as DSH hospitals under Section 148.120(a); or

B) Infants who have not attained the age of one year by hospitals that do not meet the definition of a DSH hospital under Section 148.120.

3) Claims with total covered charges equal to or above the mean total covered charges plus one standard deviation shall be considered for outlier adjustments once the following calculations have been performed:

A) Total covered charges (less charges attributable to medical

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education) equal to or exceeding one standard deviation above the mean shall be multiplied by the hospital's cost to charge ratio.

B) The hospital's rate for services provided on the claim shall be multiplied by the number of covered days on the claim.

C) The product of subsection (3) (B) above shall be subtracted from the product of (A) above.

D) The difference of subsection (3) (C) above shall be multiplied by .25, the product of which shall be the outlier adjustment for the claim.

E) Third party payments (credits) shall be applied to the final payment made on the claim.

c) The determination of those services qualified for an outlier adjustment shall be made in accordance with 89 Ill. Adm. Code 149.105 for hospitals reimbursed on a per case basis.

d) Definition of terms relating to outlier adjustments are as follows:

1) "Base fiscal year" means the hospital's fiscal year cost report most recently audited by the Department.

2) "Cost of Charge Ratio" means the hospital's Medicaid total allowable cost for all care divided by the Medicaid total covered charges for all care. The Cost to Charge Ratio is derived by utilizing cost report data from the hospital's base fiscal year.

3) "Mean total covered charges" means the mean total covered charges (as described in subsection (5) below), for services provided in the most recent state fiscal year for which complete information is available and which have been adjudicated by the Department, as follows:

A) For hospitals that do not meet the definition of a DSH hospital under Section 148.120(a) in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of one year; and

B) For hospitals defined by the Department as DSH hospitals under Section 148.120(a) in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of six years.

4) "Rate for services provided" means the inpatient rate in effect for the type of services provided.

5) "Total covered charges" means the amount entered on the UB-82 or UB-92 Uniform Billing Form for revenue code 001 in column 53 (Total Charges).

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.140 Hospital Outpatient and Clinic Services

a) Fee-For-Service Reimbursement

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1) Reimbursement for hospital outpatient hospital-based and clinic services shall be made on a fee for service basis, except for:

A) Those services that meet the definition of the Hospital Ambulatory Care Program as described in subsection (b) of this Section, which shall be reimbursed in accordance with subsections (b)(4) and (b)(5) of this Section, and adjusted in accordance with subsection (b)(7) of this Section; and

B) ESRDT services, as described in subsection (c) of this Section, which shall be reimbursed in accordance with subsection (c) of this Section, and adjusted in accordance with subsection (c)(5) of this Section; and

C) Those services provided by a Certified Pediatric Ambulatory Care Center (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), which shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b).

2) Fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.

3) With respect to those encounter rate hospitals described in Section 148.25(b)(2)(A) and (b)(2)(B), the reimbursement rate described in subsection (a)(2) above shall be adjusted in accordance with subsection (d)(7)(B) of this Section.

4) Healthy Moms/Healthy Kids rates, as described in 89 Ill. Adm. Code 140 Table M, shall be paid to Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A) and Section 148.25(b)(5)(A), Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and Section 148.25(b)(5)(B), and Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C) and Section 148.25(b)(5)(C). Healthy Moms/Healthy Kids rates shall also be paid to Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), that are provided to non-assigned Healthy Moms/Healthy Kids program clients, as described in 89 Ill. Adm. Code 140.464(b)(1).

5) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b)(2) for assigned clients.

b) Hospital Ambulatory Care Program

Effective April 1, 1986, the Department liberalized the list of allowable ambulatory procedures to add many surgical, diagnostic and

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highly technical treatment procedures that can be performed and reimbursed on an ambulatory basis.

1) Hospital Ambulatory Care Groupings
Under the Hospital Ambulatory Care Program, a Hospital Ambulatory Care list was developed that defines those technical procedures that require the use of the hospital outpatient or hospital-based clinic setting, its technical staff and/or equipment. These procedures were separated into four separate groupings based upon the complexity and historical costs of the procedures. The four separate groupings are as follows:
A) Group I procedures are high level technology surgeries that consume many hospital resources and are costly to deliver.
B) Group II procedures are certain nonsurgical, very high level technology services recognized and approved by the Department as safe outpatient procedures.
C) Group III procedures are other surgical, specialized cardiac and diagnostic procedures.
D) Group IV procedures are specialized treatment procedures, observation services, high risk, and emergency room services.

2) Hospital Ambulatory Care List Updating
The Hospital Ambulatory Care List is updated periodically. As technology changes, so do the procedures that fall into the four categories. In addition, annual changes in the ICD-9-CM procedure codes and their meanings necessitate annual changes to the Hospital Ambulatory Care List.

3) Hospital Ambulatory Care Reimbursement Prior to July 1, 1995 ~~October 1, 1993~~
Reimbursement for Hospital Ambulatory Care procedures was initially developed in 1986. For each of the four separate groupings identified in subsection (b)(1) above, a set rate maximum has been developed based upon the complexity of the procedures, historical costs, and teaching status of the hospital, the type of hospital, and the setting in which the procedure would most likely be performed (i.e., outpatient department, general clinic department, psychiatric clinic department, or rehabilitation clinic department). These set rate maximums have been periodically adjusted since 1986 based upon the above factors. Reimbursement for Hospital Ambulatory Care procedures performed prior to July 1, 1995 ~~October 1, 1993~~, shall be reimbursed in accordance with the statutes and administrative rules governing the time period when the services were rendered.

4) Hospital Ambulatory Care Reimbursement Effective July 1, 1995 ~~October 1, 1993~~
Effective October 1, 1993, reimbursement for Hospital Ambulatory Care procedures shall be as follows:
A) With respect to Group I procedures described in subsection (b)(1)(A) above, reimbursement shall be at the lesser of charges or the hospital's alternate reimbursement rate equivalent to the rate, as defined in Section 148.270(a), of a one-day inpatient stay.
B) With respect to Group II procedures described in subsection (b)(1)(B) above, reimbursement shall be at the lesser of charges or one of two separate rate maximums depending upon whether the hospital is classified as:
i) A ~~major teaching hospital as defined in Section 148.25(d), or a~~ children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3); or
ii) A hospital defined in Section 148.25(d) ~~148.25(e)~~ through (f).
C) With respect to the Group III procedures described in subsection (b)(1)(C) above, reimbursement shall be at the lesser of charges or one of two separate rate maximums depending upon whether the hospital is classified as:
i) A ~~major teaching hospital, as defined in Section 148.25(d), or a~~ children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3); or
ii) A hospital defined in Section 148.25(d) ~~148.25(e)~~ through (f).
D) With respect to the Group IV procedures described in subsection (b)(1)(D) above, reimbursement shall be at the lesser of charges or one of six separate rate maximums depending upon whether the hospital is classified as:
i) A ~~major teaching hospital, as defined in Section 148.25(d), or a~~ children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3); or
ii) A hospital defined in Section 148.25(d) ~~148.25(e)~~ through (f); and
iii) Whether the service is provided in the outpatient, general clinic, psychiatric clinic, or rehabilitation clinic department.

~~5) Outpatient Indigent Volume Adjustment~~
~~Effective with outpatient services provided on or after October 1, 1993, the Department shall make outpatient indigent volume adjustment payments to the amounts reimbursed under subsections (b)(4)(B) through (b)(4)(B) of this Section to a cost reporting hospital, as described in Section 148.210(a), other than to those hospitals described in Sections 148.25(b)(2)(A), 148.25(b)(2)(B), 148.25(b)(2)(D), 148.25(b)(3), or 148.25(b)(5)(B), subject to the provisions of subsection (b)(5)(C) below. The outpatient indigent volume adjustment payments shall be in addition to the amounts reimbursed under subsections (b)(4)(B) through (b)(4)(B) above.~~
~~A) Outpatient indigent volume adjustment payments shall be calculated by multiplying the payment to be made by the Department in accordance with subsections (b)(4)(B) through~~

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~~(b)(4)(B)--above--by--the--sum--of-the-hospital's-outpatient indigent-volume-factor-and-1.00.~~

~~B) A-hospital's-outpatient--indigent--volume--factor--shall--be calculated-annually-as-follows:~~

~~i) The-hospital's-Medicaid-inpatient-utilization-rate,-as described-in-subsection-(b)(5)(B)(ii)-of-this-Section, shall--be--added--to-the-hospital's-uncompensated-care utilization-rate.~~

~~ii) The-sum-of-the--calculation--described--in--subsection (b)(5)(B)(i)-above-shall-be-multiplied-by-0.5.~~

~~C) In--order--to--be--eligible--for--outpatient-indigent-volume adjustment--payments,--a--hospital--must--submit--the---data required--under--Section--148.150--in--accordance--with--the requirements-of-Section-148.150.~~

~~i) As--a--condition--of--eligibility--for--an--outpatient indigent--volume--adjustment--for--outpatient-services provided-on-or-after-October-1,-1993,-and-on-or-before December-31,-1993,-hospitals-that-did-not-comply--with the--data--requirement-described-in-Section-148.150(c) shall-be-required-to-submit,-on-or-before--October--1, 1993,-the-data-required-under-Section-148.150(d).~~

~~ii) Subject-to-the-provisions-of-subsection-(b)(5)(C)(iii) below,--a--hospital--that--did--not--comply--with--the requirements--of--subsection--(b)(5)(C)(i)-above-on-or before-October-1,-1993,--shall--not--be--eligible--for outpatient--indigent-volume-adjustments-for-outpatient services-provided-on-or-after-October-1,-1993,-and--on or-before-September-30,-1994.~~

~~iii) Notwithstanding----the----provisions---of---subsection (b)(5)(C)(ii)-above,-a-hospital--that--has--failed--to comply----with----the---requirements---of---subsection (b)(5)(C)(i)-above-on-or-before-October-1,--1993,--but does--comply--with--such--requirements--on--or--before November--5,--1993,-shall-be-ineligible-for-outpatient indigent-volume-adjustments--for--outpatient--services provided-on-or-after-October-1,-1993,-and-on-or-before December---31,---1993,---but--shall--be--eligible--for outpatient-on-or-after-January--1,--1994,--and--on--or before-September-30,-1994.~~

~~iv) Effective--with---outpatient--services--provided--on-or after-October-1,-1994,-as-a-condition--of--eligibility for--outpatient-indigent-volume-adjustments,-hospitals that--did--not--comply--with--the---date---requirement described--in--Section-148.150(c)-shall-be-required-to submit,-by-the-first-day-of-October-of-each-year,--the data--described--in-148.150(c)-in-addition-to-the-data required-under-148.150(d).---A-hospital-that--does--not comply--with--these-data-requirements-by-the-first-day of-October--of--each--year--shall--be--ineligible--for outpatient--indigent--volume--adjustments-for-the-rate period.~~

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~~B) Outpatient--Indigent--Volume--Adjustment--Definitions.---The definitions-of-terms-used-with-reference-to--calculation--of the-outpatient-indigent-volume-adjustments-are-as-follows:~~

~~i) "Base--fiscal-year"-means,-for-example,-the-hospital's fiscal-year-ending-in-1991-for-the--October--1,--1993, outpatient--indigent--volume--determination--year,-the hospital's-fiscal-year-ending-in-1992-for-the--October 1,--1994,--outpatient--indigent--volume--determination year,-etc.~~

~~ii) "Medicaid---inpatient---utilization--rate"--means--the percent---of---Medicaid---inpatient---utilization---as determined-in-accordance-with-Section-148.120.~~

~~iii) "Rate-period"-means,-for-dates-of-service-on-or--after October--1,-1993,-the-twelve-month-period-beginning-on October-1-of-the-year-and-ending-on--September--30--of the-following-year.~~

~~iv) Uncompensated--care--base-year"-means-August-1-through July-31-of-each-year-beginning-with-the-initial-August 1,-1990,-through-July-31,-1991,-base-year.~~

~~v) "Uncompensated--care--utilization--rate"---means---the percent-of-uncompensated-care-determined-in-accordance with--Section--148.150--in-the-uncompensated-care-base year.~~

5)~~6)~~ No Year-End Reconciliation

With the exception of the retrospective rate adjustment described in subsection (d)(7) of this Section, no year-end reconciliation is made to the reimbursement rates calculated under subsection (b).

6)~~7)~~ Rate Adjustments

With respect to those hospitals described in Sections 148.25(b)(2)(A), the reimbursement rates described in subsection (b)(4) above shall be adjusted on a retrospective basis. The restrospective adjustment shall be calculated as follows:

A) The reimbursement rates described in subsection (b)(4) above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

7)~~8)~~ Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient

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facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals reimbursed under the Ambulatory Care Program in the same manner as to encounter rate hospitals and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.

8)~~9)~~ Hospitals described in Sections 148.25(b)(2)(A) and (b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close after the facility's fiscal year.

c) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) shall be made at the Department's payment rates, as follows:

1) For inpatient hospital services provided pursuant to Section 148.40(c)(1), the Department shall reimburse hospitals pursuant to Sections 148.240 through 148.300 and 89 Ill. Adm. Code 149.

2) For outpatient services or home dialysis treatments provided pursuant to Sections 148.40(c)(2) or 148.40(c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate which will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.2163 ~~405.231(c)~~ (1994) ~~(1984)~~. This rate will be that rate established by Medicare pursuant to 42 CFR 405.2124 ~~405.439~~ and 405.2130 ~~405.441~~ (1994) ~~(1989)~~.

3) Payment for non-routine services. For services which are provided during outpatient or home dialysis treatment pursuant to Sections 148.40(c)(2) or 148.40(c)(3) but are not defined as a routine service under 42 CFR 405.2163 ~~405.231(c)~~ (1994) ~~(1989)~~, separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.450, and 140.475 through 140.481, respectively.

4) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.

5) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in this subsection (c) shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as provided in subsection (d) of this Section.

d) Non Hospital Based Clinic Reimbursement

1) County-Operated Outpatient Facility Reimbursement
Reimbursement for all services provided by county-operated outpatient facilities, as described in Section 148.25(b)(2)(C), that do not qualify as Healthy Moms/Healthy Kids Managed Care clinics, as described in 89 Ill. Adm. Code 140.46(f), shall be on an all-inclusive per encounter rate basis as follows:

A) Base Rate. The per encounter base rate shall be calculated

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as follows:

i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.

ii) The resulting quotient, as calculated in subsection (d)(1)(A)(i) above, shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.

iii) The resulting product, as calculated in subsection (d)(1)(A)(ii) above, shall be added to the resulting quotient, as calculated in subsection (d)(1)(A)(i) above to determine the per encounter base rate.

iv) The resulting sum, as calculated in subsection (d)(1)(A)(iii) above, shall be the per encounter base rate.

B) Supplemental Rate

i) The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.

ii) The supplemental service cost shall be multiplied by the allowable overhead rate factor. The allowable overhead rate factor is calculated by dividing the product derived in subsection (d)(1)(B)(ii) above by the quotient derived in subsection (d)(1)(B)(i) above.

iii) The quotient derived in subsection (d)(1)(B)(i) above, shall be added to the product derived in subsection (d)(1)(B)(ii) above, to determine the per encounter supplemental rate.

iv) The resulting sum, as described in subsection (d)(1)(B)(iii) above, shall be the per encounter supplemental rate.

C) Final Rate

i) The per encounter base rate, as described in subsection (d)(1)(A)(iv), shall be added to the per encounter supplemental rate, as described in (d)(1)(B)(iv), to determine the per encounter final rate.

ii) The resulting sum, as determined in subsection (d)(1)(C)(i) above, shall be the per encounter final rate.

iii) The per encounter final rate, as described in subsection (d)(1)(C)(ii) above, shall be adjusted in accordance with subsection (d)(2)(A) below.

2) Rate Adjustments
In the case of encounter rate hospitals described in Sections 148.25(b)(2)(A), 148.25(b)(2)(B), and 148.25(b)(2)(D), rate adjustments to the per encounter final rate, as described in subsection (d)(1)(C)(iii) above, shall be calculated as follows:

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A) The reimbursement rates described in subsections (d)(1)(A) and (d)(1)(C) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

3) County-operated outpatient facilities, as described in Section 148.25(b)(2)(C), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (d).

4) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to encounter rate hospitals in the same manner as to hospitals reimbursed under the Ambulatory Care Program and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.150 Public Law 103-66 Requirements ~~Uncompensated Care Payment Adjustments~~

a) ~~The Department shall make uncompensated care payments to qualified hospitals. The Department shall adjust each of these uncompensated care payments to ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42 CFR 447.272, Application of Upper Payment Limits.~~

b) ~~For the period August 1, 1991 through September 30, 1992, the hospital's uncompensated care payment shall be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered.~~

c) ~~As a condition of eligibility for an uncompensated care payment adjustment during the uncompensated care rate year, each hospital shall submit, on or before October 1 of the uncompensated care rate year, the following information separated by inpatient and outpatient (including hospital based clinic services) to the Department for the period August 1, 1990 through July 31, 1991.~~

1) ~~The dollar amount of uncompensated care charges rendered in the period described above.~~

2) ~~The dollar amount of charges rendered during this period reimbursed by the Department under General Assistance (Article VI of the Public Aid Code) or Aid to the Medically Indigent (Article VII of the Public Aid Code).~~

3) ~~The dollar amount of Medicaid charges rendered in the period described above.~~

4) ~~The dollar amount of total charges for care rendered in the period described above.~~

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d) ~~Effective on or after October 1, 1992, as a condition of eligibility for an uncompensated care payment adjustment for the uncompensated care rate year, each~~ Each cost reporting hospital as described in Section 148.210 shall annually submit, on or before August 15 ~~October 1~~ of the ~~uncompensated care~~ rate year, at least the following information separated by inpatient and outpatient (including hospital-based clinic services) to the Department:

1) The dollar amount of uncompensated care charges rendered in the ~~previous uncompensated care~~ base year.

2) The dollar amount of charges rendered in the ~~previous uncompensated care~~ base year that are reimbursable by the Department for those program participants covered under the Family and Children Assistance Program, formerly known as the General Assistance Program (Article VI of the Public Aid Code).

3) The dollar amount of Medicaid charges rendered in the ~~previous uncompensated care~~ base year.

4) The dollar amount of total charges for care rendered in the ~~previous uncompensated care~~ base year.

e) ~~Condition of Eligibility Data Requirements~~

1) ~~Effective with the October 1, 1992, uncompensated care rate year, as a condition of eligibility for an uncompensated care payment adjustment for the uncompensated care rate year, hospitals that did not comply with the data requirements described in subsection (c) above shall submit, on or before October 21, 1992, the data required under subsection (c) above in addition to the data required under subsection (d) above.~~

2) ~~With respect to the October 1, 1993, uncompensated care rate year:~~

A) ~~As a condition of eligibility for the total uncompensated care payment adjustment for the October 1, 1993, uncompensated care rate year, hospitals that did not comply with the data requirement described in subsection (c) above for the initial uncompensated care base year shall be required to submit, on or before October 1, 1993, the data described in subsection (c) above in addition to the data required under subsection (d) above.~~

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B) Subject to the provision of subsection (e)(2)(C) below, a hospital that did not comply with the requirements of subsection (e)(2)(A) above on or before October 1, 1993, shall not be eligible for uncompensated care payment adjustments for the October 1, 1993, uncompensated care rate year.

C) Notwithstanding the provisions of subsection (e)(2)(B) above, a hospital that has failed to comply with the requirements of subsection (e)(2)(A) above on or before October 1, 1993, but does comply with such requirements on or before November 5, 1993, shall be ineligible for the first quarterly uncompensated care payment adjustment, but shall be eligible for the final three quarterly uncompensated care payment adjustments, subject to the requirements of subsection (j) of this Section.

3) Effective on or after October 1, 1994, as a condition of eligibility for an uncompensated care payment adjustment for the uncompensated care rate year, hospitals that did not comply with the data requirement described in subsection (c) above for the initial uncompensated care base year shall be required to submit, by the first day of October of the uncompensated care rate year, the data described in subsection (c) above in addition to the data required under subsection (d) above. A hospital that does not comply with these data requirements by the first day of October of the uncompensated care rate year shall be ineligible for uncompensated care payment adjustments in the uncompensated care rate year.

f) The data submitted under subsections (c), (d) and (e) above shall contain a statement signed by the chief financial officer or chief executive officer certifying to the accuracy of the data submitted.

g) Effective with the October 1, 1992, uncompensated care rate year, all hospitals that are reimbursed under Sections 148.170, 148.250 through 148.300, or 89 Ill. Adm. Code 149 that are required to submit cost reports in accordance with Section 148.210(a) shall be eligible for an uncompensated care payment adjustment for the uncompensated care rate year subject to the reporting requirements of subsections (c), (d) and (e) above, and the provision of subsection (j) below. The uncompensated care payment for the uncompensated care rate year shall be calculated by multiplying the number of Medicaid days, excluding days for normal newborns, provided by the hospital in the uncompensated care base fiscal year which were subsequently adjudicated by the Department through the last day of June preceding the uncompensated care rate year and contained within the Department's paid claims data base by $52.65.

h) Effective on or after October 1, 1993, all hospitals that are reimbursed under Sections 148.250 through 148.300, or 89 Ill. Adm. Code 149, that are required to submit cost reports in accordance with Section 148.210(a) shall be eligible for an uncompensated care payment

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adjustment for the uncompensated care rate year subject to the reporting requirements of subsections (c), (d) and (e) above, and the provisions of subsection (j) below. The uncompensated care payment for the uncompensated care rate year shall be calculated by multiplying the number of Medicaid days, excluding days for normal newborns, provided by the hospital in the uncompensated care base fiscal year which were subsequently adjudicated by the Department through the last day of June preceding the uncompensated care rate year and contained within the Department's paid claims data base by $52.65.

i) In addition to the amount calculated in subsections (g) and (h) above, for the period July 1, 1993, through June 30, 1994, each hospital shall receive an additional uncompensated care payment adjustment. This additional uncompensated care payment adjustment shall be calculated by dividing $16.5 million by the number of Medicaid days, excluding days for normal newborns, provided by all hospitals in the uncompensated care base fiscal year which were subsequently adjudicated by the Department through the last day of June preceding the uncompensated care rate year and contained within the Department's paid claims data base.

j) Effective on or after October 1, 1992, a hospital will not be eligible for an uncompensated care payment adjustment under this Section for uncompensated care rate year if the data supplied under subsections (c), (d) and (e) above indicate a significant decrease in the uncompensated care utilization rate. This determination will be made by comparing the level of uncompensated care provided in the base year to the level of uncompensated care provided in the initial base year of August 1, 1990 through July 31, 1991. For purposes of this determination, uncompensated care in the base year of August 1, 1990, through July 31, 1991, and in subsequent uncompensated care base years shall, in addition to its usual definition, include charges for services reimbursable by the Department under the Family and Children Assistance Program, formerly known as General Assistance (Article VII), and Aid to the Medically Indigent (Article VII). For example, eligibility for a payment adjustment for the uncompensated care rate year beginning October 1, 1992, shall be subject to a determination that there is not a significant decrease in the uncompensated care utilization rate provided from August 1991 through July 1992 as compared to the level of uncompensated care provided from August 1990 through July 1991. Factors which the Department may consider in determining whether a significant decrease in uncompensated care has occurred may include, but not be limited to, a change in the socio-economic characteristics of the community.

k) Reimbursement for uncompensated care payment adjustments shall be made on a quarterly basis.

l) All hospitals eligible for an uncompensated care payment adjustment shall be deemed to have met the requirements of Section 5-17 of the

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~~Public--Aid--Code--that--hospitals--provide--equal-access-to-available services-to-low-income-persons-who-are-eligible-for--assistance--under Articles--V,--VI--and--VII--of--the--Public-Aid-Code.--Nothing-in-this subsection-shall-be--construed--to--imply--that--a--hospital--that--is ineligible--for--an--uncompensated-care-payment-adjustment-has-not-met the-requirements-of-Section-5-17-of-the-Public-Aid-Code.~~

~~m) Inpatient-Payment-Adjustments-Based-Upon--Uncompensated--Care--Payment Adjustment-Reviews.--Appeals-based-upon-a-hospital's-ineligibility-for the--uncompensated-care-payment-adjustments-described-in-this-Section, or-their--payment--adjustment--amounts,--in--accordance--with--Section 14B.31B,--which--result--in--a--change-in-a-hospital's-eligibility-for uncompensated-care-payment-adjustments-or-a--change--in--a--hospital's uncompensated--care--payment--adjustment-amounts,-shall-not-affect-the uncompensated-care-payment-adjustments-of-any-other-hospital-that--has received--notification--from--the--Department-of-their-eligibility-for uncompensated-care-payment-adjustments-based-on--the--requirements--of this-Section.~~

b)~~n)~~ Definitions

1) "Medicaid charges" means hospital charges for inpatient, outpatient and hospital-based clinic services provided to recipients of medical assistance under Title XIX of the Social Security Act.

2) ~~"Medicaid-days" means-hospital-days-reimbursed-by-the--Department for--recipients--of--medical--assistance--under--Title-XIX-of-the Social-Security-Act.~~

~~3)~~ "Total charges" means the total amount of a hospital's charges for inpatient, outpatient and hospital-based clinic services it has provided.

~~4) "Uncompensated-care-base-fiscal-year" means,-for--example,--State Fiscal--Year--1991,--for--the-October-1,-1992,-uncompensated-care rate-year,-State-Fiscal-Year--1992,--for--the--October--1,--1993, uncompensated-care-rate-year,-etc.~~

3)~~5)~~ "Uncompensated--care-base Base year" means July ~~August~~ 1 through June 30 ~~July-31~~ of each year, beginning with ~~the-initial~~ July 1, 1994 ~~August--1,--1990~~, through June 30, 1995 ~~July-31,-1991~~, base year.

4)~~6)~~ "Uncompensated care charges" for a hospital means:

A) the hospital's charges for inpatient, outpatient and hospital-based clinic services for which the hospital was not reimbursed by either the patient or a third party (including the Department);

B) less:

i) the amount of the hospital's bad debt recoveries for inpatient, outpatient and hospital-based clinic services; and

ii) the hospital's charges attributable to inpatient, outpatient and hospital-based clinic services that it provided without charge or at reduced charges under

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its obligation under the federal Hill-Burton Act (42 U.S.C. 291 et seq.).

~~7) "Uncompensated-care-rate-year" means-October-1-through--September 30-of-each-year,-beginning-with-the-October-1,-1992-rate-year.~~

~~8) "Uncompensated--care--utilization--rate"--means--a--fraction,-the numerator-of-which-is-the-hospital's-uncompensated--care--charges provided--in--a-given-twelve-month-period,-and-the-denominator-of which-is-the-hospital's-total-charges-in-that--same--period.---In this--paragraph,--the--term--"uncompensated--care--charges"-shall include,--in--addition--to--its--usual--definition,--charges--for services-reimbursable-by-the--Department--under--the--Family--and Children-Assistance-Program,-formerly-known-as-General-Assistance (Article-VI),-and-Aid-to-the-Medically-Indigent-(formerly-Article VII).~~

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.160 Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three ~~3-Million~~

a) Reimbursement Methodology
In accordance with 89 Ill. Adm. Code 149.50(c)(8), county-owned hospitals in an Illinois county with a population greater than three million are excluded from the DRG PPS and are reimbursed in accordance with this ~~section~~ Section.

b) Base Year Costs

1) The hospitals' base year operating costs shall be contained in the hospitals' audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospital fiscal years ending between 20 and 31 months prior to the fiscal year for which rates are being set.

2) The hospitals' base year capital related costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) above.

3) The hospitals' base year direct medical education costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) above.

4) The base year cost per diem shall be the sum of the operating cost per diem, capital related cost per diem and medical education cost per diem defined in subsections (b)(1) through (b)(3).

5) New hospitals, for which a base year cost report is not on file, will be reimbursed the per diem rate calculated in subsection (b)(4) above and inflated in subsection (d)(1) below.

c) Restructuring Adjustment
Adjustments to the base year cost per diem, as described in subsection (b)(4) above, will be made to reflect restructuring since filing the base year cost reports. The restructuring must have been mandated to

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meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost reports to determine restructuring costs. If audited cost reports become available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Office of Health Finance, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Finance Section between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the reports are received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies, and added to the base year cost per diem, as described in subsection (b)(4), which is subject to the inflation adjustment described in subsection (d) below.

d) Inflation Adjustment For Base Year Cost Report Inflator
   1) The base year cost per diem, as defined in subsection (b)(4) above, shall be inflated from the midpoint of the hospitals' base year to the midpoint of the time period for which rates are being set (rate period) according to the historical rate of annual cost increases. The historical rate of annual cost increases shall be calculated by dividing the operating cost per diem as defined in subsection (b)(1) above by the previous year's operating cost per diem.
   2) Effective October 1, 1992, the final reimbursement rate shall be no less than the reimbursement rate in effect on June 1, 1992; except that this minimum shall be adjusted each July 1 thereafter by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports.

e) Review Procedure
   The review procedure shall be in accordance with Section 148.310.

f) Applicable Adjustments for DSH Hospitals
   1) The criteria and methodology for making applicable adjustments to DSH hospitals which are exempt from the DRG PPS, as described in subsection (a) above, shall be in accordance with Section 148.120.
   2) In addition to the DSH payment adjustment described in Section 148.120, hospitals reimbursed under this Section shall receive

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supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in subsection (b)(4) above, as adjusted for restructuring, as described in subsection (c) above, and as adjusted for inflation, as described in subsection (d) above, and the calculated disproportionate share per diem payment adjustment as described in Section 148.120, by the hospitals' percentage of changes which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. Effective October 1, 1992, the supplemental DSH payments calculated under this subsection shall be no less than the supplemental DSH rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid cost by the total allowable Medicaid days. The supplemental DSH payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.

g) Outlier Adjustments
   Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.

h) Trauma Center Adjustments. Trauma center adjustments shall be made in accordance with Section 148.290(c).

i) Reductions to Total Payments
   1) Copayments. Copayments are assessed under all medical programs administered by the Department except the Family and Children Assistance Program, formerly known as the General Assistance Program, and shall be assessed in accordance with Section 148.190.
   2) Third Pary Payments. The requirements of Section 148.290(j)(2) shall apply.

j) Prepayment and Utilization Review
   Prepayment and utilization review requirements shall be in accordance with Section 148.240.

k) Cost Reporting Requirements
   Cost reporting requirements shall be in accordance with Section 148.210.

l) Rate Period
   The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act

a) In accordance with 89 Ill. Adm. Code 149.50(c)(8), a hospital organized under the University of Illinois Hospital Act shall be excluded from the DRG PPS and shall be reimbursed in accordance with this Section.

b) Base Year Costs

1) Each hospital's base year cost per diem shall be derived from an audited cost report (see 42 CFR 447.260 and 447.265 (1982)) for hospitals' fiscal year 1992 ~~1990~~.

2) For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.

c) Restructuring Adjustment

Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Finance Section, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Office of Health Finance between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the report is received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the

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midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year costs.

d) Inflation Adjustment For Base Year Cost Report Inflator

Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set according to the hospital's historical rate of annual cost increases.

e) Review Procedure

The review procedure shall be in accordance with Section 148.310.

f) Applicable adjustments for DSH Hospitals

1) The criteria and methodology for making applicable adjustments to DSH hospitals which are exempt from the DRG PPS as described in subsection (a) above, shall be in accordance with Section 148.120.

2) Effective October 1, 1993, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall have supplemental DSH payments effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's base year costs, as described in subsection (b) above, as adjusted for restructuring, as described in subsection (c) above, and as adjusted for inflation, as described in subsection (d) above, and the calculated disproportionate share per diem payment adjustment as described in Section 148.120 by the hospital's percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. The resulting product shall be multiplied by 1.50 ~~2.25~~ and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

g) Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.

h) Reductions to Total Payments

1) Copayments. Copayments are assessed under all medical programs administered by the Department except the Children and Family Assistance Program, formerly known as the General Assistance Program, and shall be assessed in accordance with Section 148.190.

2) Third Party Payments. The requirements of Section 148.290(j)(2) shall apply.

i) Prepayment and Utilization Review

Prepayment and utilization review requirements shall be in accordance with Section 148.240.

j) Cost Reporting Requirements

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Cost reporting requirements shall be in accordance with Section 148.210.

k) Rate Period
The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year. Except for the period of July 1, 1995, through September 30, 1995.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals

The exempt hospitals, defined in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), (c)(4) and (c)(7), shall be reimbursed for inpatient hospital care provided to recipients by summing the following reimbursement calculations:

a) allowable operating cost per diem;
b) ~~other--costs--(~~capital ~~and--direct--medical--education--costs)~~ costs reimbursed on a per diem basis;
c) applicable DSH adjustments as described in Section 148.120, ~~uncompensated--care--adjustments--as-described-in-Section-148.150,~~ and outlier adjustments as described in Section 148.130; and
d) applicable trauma center adjustments, as described in 89 Ill. Adm. Code 148.290(c), ~~rehabilitation-hospital-adjustments,-as-described-in 89--Ill.--Adm.--Code--148.290(d),--perinatal--center--adjustments,--as described--in--89--Ill.--Adm.--Code---148.290(e),---obstetrical---care adjustments,--as--described--in-89-Ill.-Adm.-Code-148.290(f),-targeted access--payment--adjustments,--as--described--in--89--Ill.--Adm.--Code 148.290(g),~~ and Medicaid high volume adjustments, as described in 89 Ill. Adm. Code 148.290(d) ~~148.290(h)~~.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.260 Calculation and Definitions of Inpatient Per Diem Rates

a) Calculation for the first rate year period
1) Allowable operating cost per diem
A) The allowable operating cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units described in Section 148.270(a) and (b), shall be calculated by taking the hospital's Medicaid inpatient operating costs divided by the hospital's Medicaid inpatient days.
B) Operating cost base per diem rates for hospital inpatient care provided to Medicaid recipients beginning September 1, 1991, shall be calculated by:

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i) Calculating each individual hospital's cost per diem less capital and direct medical education costs for each of the two most recent years for which an audited Medicaid cost report exists, as described in subsection (a)(1)(A) above.
ii) Each of the two costs per diem shall be trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).
iii) These two trended operating costs per diem are then added together and divided by two ~~to-calculate-the hospital's-final-operating-cost-per-diem-for-the--base period~~.
iv) The average operating cost per diem calculated in subsection (a)(1)(B)(iii) above is then divided by the indirect medical education (IME) factor, determined by the Health Care Financing Administration (HCFA) in effect ninety days prior to the admission in order to calculate the hospitals final operating cost per diem for the base period. For other hospitals for which an indirect medical education factor is not available, the Department shall calculate an indirect medical education factor using the hospital's most recently available cost report and the Medicare formula in effect 90 days prior to the date of admission.

2) Capital Related Costs. The capital related cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking the hospital's total capital related costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).
A) These two trended capital related costs per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.
B) The adjusted capital related cost per diem, as calculated in subsection (a)(2)(A) above, shall be rank ordered for all hospitals and capped at the 80th percentile.
C) Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (a)(2)(A) or subsection (a)(2)(B) above, whichever is less.

3) Direct Medical Education Costs. The direct medical education cost per diem for a hospital, described in Section 148.250, and for hospitals or hospital units, described in Section 148.270(a) and (b), shall be calculated by taking total inpatient direct medical education costs for the base period as defined in Section 148.25(g)(1) divided by the hospital's total inpatient days,

trended forward to the midpoint of the rate period using the national hospital market basket price proxies (DRI).

A) The two trended direct medical education costs per diem are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.

B) The adjusted direct medical education cost per diem, as calculated in subsection (a)(3)(A) above, shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.

C) Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in subsection (a)(3)(A) or subsection (a)(3)(B) above, whichever is less.

~~b) Calculation of Direct Medical Education Costs for Subsequent Rate Periods~~

~~1) Effective with rate periods beginning on or after April 1, 1994, hospitals will be separated into two peer groups for the purpose of computing direct medical education cost per diems.~~

~~2) For the purpose of computing the direct medical education cost per diems, all hospitals described in Section 148.25(d) shall be defined as major teaching hospitals. All other hospitals reporting direct medical education costs shall be defined as other teaching hospitals.~~

~~3) Effective with rate periods beginning on or after April 1, 1994, the adjusted direct medical education cost per diem for all hospitals in each peer group shall be calculated by utilizing the direct medical education cost per diems for each hospital that were in effect on June 30, 1993, under the methodology described in subsections (a)(3) and (a)(3)(A) of this Section.~~

~~A) The adjusted direct medical education cost per diem, as described in subsection (b)(3) above, shall be rank ordered for all hospitals reporting such costs within each peer group, and capped at the 80th percentile.~~

~~B) Each hospital shall receive a per diem add on for direct medical education costs which shall be equal to the amount calculated in subsection (b)(3) or subsection (b)(3)(A) above, whichever is less, subject to the inflation adjustment described in subsection (c) of this Section.~~

~~c)~~b) Calculation for Subsequent Rate Periods

1) For the rate period describing in Section 148.25(g)(2)(A), the final rate per diem shall be determined by taking the operating, capital and direct medical education trended rate costs per diems calculated under subsection (a) of this Section and updating those costs by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(A).

2) For rate periods beginning on or after April 1, 1994, as described in Section 148.25(g)(2)(B), the final rate per diem

shall be determined by:

A) Adding the operating and capital trended rate cost per diems calculated under subsection (a) of this Section that were in effect on June 30, 1993;

~~B) Adding the direct medical education trended rate cost per diem calculated under subsection (c) of this Section to the resulting sum described in subsection (c)(2)(A) above; and~~

~~c)~~B) Updating the trended rate cost per diems described in subsection (b)(2)(A) ~~subsections (c)(2)(A) and (c)(2)(B)~~ above;

i) In the case of a hospital described in 89 Ill. Adm. Code 149.125(b), by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section 148.25(g)(2)(B); and

ii) In the case of a hospital described in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), or (c)(4), or for a hospital unit described in 89 Ill. Adm. Code 149.50(d)(1) or (d)(2), to the midpoint of the current rate period described in Section 148.25(g)(2)(B) by utilizing the TEFRA price inflation factor.

c)~~d)~~ Rebasing

For the rate period beginning after October 1, 1994, and every third rate period thereafter, the final rate per diem shall be calculated using the~~:~~ ~~1)~~ ~~The~~ methodology set forth in subsection (a) of this Section for the calculation of operating and capital trended rate cost per diems using base period cost reports, as described in Section 148.25(g)(1)~~.~~ ~~,~~ and

~~2) The methodology set forth in subsection (c) of this Section for the calculation of direct medical education trended rate cost per diems using base period cost reports, as described in Section 148.25(g)(1).~~

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.270 Determination of Alternate Cost Per Diem Rates for All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals

a) Calculation of Alternate Cost Per Diem Rates for All Hospitals
For all hospitals, regardless of the hospital's reimbursement methodology, the Department shall first calculate the hospital's alternate cost per diem rate, as calculated under Section 148.260, derived from the provider's base period cost reports, as described in Section 148.25(g)(1).

b) Calculation of Payment Rates for Certain Exempt Hospital Units
1) For admissions occurring within the rate period described in Section 148.25(g)(2)(A):

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A) In the case of a distinct part unit, as described in 89 Ill. Adm. Code 149.50(d), the Department shall divide the hospital's Medicaid charges per diem (identified on adjudicated claims submitted by the provider during the most recently completed fiscal year for which complete data are available) related to the distinct part unit by the hospital's total charge per diem for all claims for the same time period.

B) The resulting quotient, as calculated in subsection (b)(1)(A) above, shall be multiplied by the hospital's total operating cost per diem, as calculated in Section 148.260(a)(1)(B).

C) The capital related cost per diem, as calculated in Section 148.260(a)(2), ~~and the direct medical education cost per diem, as calculated in Section 148.260(a)(3), are~~ is then added to the resulting product calculated in subsection (b)(1)(B) above, subject to the inflation adjustment described in Section 148.260(c)(1).

D) Subject to the provisions of subsection (b)(1)(E) and (b)(1)(F) below, the final distinct part unit payment rate shall be the lower of:

i) The result of the calculations described in subsections (b)(1)(A) through (b)(1)(~~E~~B) above; or

ii) The hospital's alternate cost per diem rate, as calculated in subsection (a) above.

E) In no case shall the hospital's final distinct part unit payment rate be greater than three standard deviations above the mean distinct part unit payment rate.

F) In the case of a new distinct part unit for which the Department has insufficient adjudicated claims history data available, the Department shall utilize the average payment rate calculated under this subsection (b)(1) for like distinct part units.

2) For admissions occurring within a rate period described in Section 148.25(g)(2)(B), the distinct part unit payment rate shall be the distinct part unit payment rate in effect on June 30, 1993, as calculated under subsection (b)(1) above, updated to the midpoint of the current rate period, using the TEFRA price inflation factor.

c) In the case of a new hospital (not previously owned or operated), a hospital that has significantly changed its case-mix profile (e.g., a general acute care hospital changing its case-mix to reflect a predominance of long term care patients), or an out-of-state non cost-reporting hospital, reimbursement for inpatient services shall be as follows:

1) For general acute-care hospitals, reimbursement for inpatient services shall be at the average payment rate calculated under subsection (a) or (b) above, as applicable, for those hospitals

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reimbursed under 89 Ill. Adm. Code 149.

2) For psychiatric hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(1), reimbursement for inpatient psychiatric services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(1).

3) For rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), reimbursement for inpatient rehabilitation services shall be at the average rate calculated under Section 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(2).

4) For long term stay hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(4), reimbursement for inpatient services shall be at the average rate calculated under Section 148.250 through 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(4).

5) For children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), reimbursement for inpatient services shall be at the average rate calculated under subsection (a) above for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(3).

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.290 Adjustments and Reductions to Total Payments

a) Applicable Adjustments for DSH ~~and Uncompensated Care~~
The criteria and methodology for making applicable DSH ~~and uncompensated care~~ adjustments to hospitals shall be in accordance with Section 148.120 ~~or, if applicable, 148.150~~.

b) Outlier Adjustments
Outlier adjustments to payments amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130 for hospitals that are exempt from the DRG PPS (see 89 Ill. Adm. Code 149).

~~c) Trauma Center Adjustments (TCA)~~
~~For inpatient admissions occurring on or after October 1, 1992, the Department shall make trauma center adjustments (TCA) to hospitals recognized, as of the first day of July preceding the TCA rate period, as Level I or Level II trauma centers by Illinois Department of Public Health, or, if applicable, by the licensing agency in the State in which the hospital is located, in accordance with the provisions of subsections (c)(1) through (c)(5) below:~~

~~1) Level I Trauma Center Adjustment (TCA). Hospitals that, on the first day of July preceding the TCA rate period, meet the following criteria shall receive an adjustment of $19,200.00 per Medicaid trauma admission in the TCA base period:~~

~~A) The hospital must not be a county owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as~~

described in Section 148.25(b)(1)(B); and

B) The hospital is recognized as a Level I trauma center by the Illinois Department of Public Health, or by the licensing agency in the State in which the hospital is located if the hospital is located within 50 miles of an Illinois border.

2) Level II Rural Trauma Center Adjustment (TCA). Illinois rural hospitals that meet the following criteria shall receive an adjustment of $9,400.00 per Medicaid trauma admission in the TCA base period:

A) With respect to the October 1, 1992 TCA rate period, on the first day of July preceding the TCA rate period, the hospital is located in a rural area and is recognized as a Level II trauma center by the Illinois Department of Public Health.

B) With respect to the October 1, 1993 TCA rate period, on July 1, 1993, the hospital is designated as a rural hospital as defined in Section 148.25(g)(3), and is recognized as a Level II trauma center by the Illinois Department of Public Health.

C) With respect to TCA rate periods beginning on or after October 1, 1994, on the first day of July preceding the TCA rate period, the hospital is designated as a rural hospital as defined in Section 148.25(g)(3), and is recognized as a Level II trauma center by the Illinois Department of Public Health.

3) Level II Urban Trauma Center Adjustment (TCA). Illinois urban hospitals, as described in Section 148.25(g)(4) for rate periods beginning on or after October 1, 1993, that, on the first day of July preceding the TCA rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of $9,400.00 per Medicaid trauma admission in the TCA base period, provided that such hospital meets the criteria described in subsections (c)(3)(B) or (c)(3)(C) below:

A) The Medicaid trauma admission percentage, as described in subsection (c)(7)(C) below, shall be calculated for each hospital described in subsection (c)(3) above.

B) Each hospital described in subsection (c)(3) that meets the following additional criteria shall be eligible for the adjustment described in subsection (c)(3) above:

i) The hospital is located in a county with no Level I trauma center; and

ii) The hospital has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (c)(3)(A) above; and

iii) The hospital is located in a Health Manpower Shortage Area (HMSA) (42 CFR 5, 1989), as of the first day of July preceding the TCA rate period year.

C) Each hospital described in subsection (c)(3) that meets the following additional criteria shall be eligible for the adjustment described in subsection (c)(3) above:

i) The hospital is located in a county with no Level I trauma center; and

ii) The hospital has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (c)(3)(A) above.

c) 4) County Trauma Center Adjustment (TCA). Illinois hospitals that, on the first day of July preceding the TCA rate period, are recognized as Level I or Level II trauma centers by the Illinois Department of Public Health, shall receive an adjustment that shall be calculated as follows:

1) A) The available funds from the Trauma Center Fund for each quarter shall be divided by each eligible hospital's (as defined in subsection (c)(4) above) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter.

2) B) The county trauma center adjustment payments shall not be treated as payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the Public Aid Code.

3) 5) Each eligible hospital's trauma center adjustment for the TCA rate period shall equal the sum of the amounts described in subsections (c)(1), (c)(2), (c)(3), and (c)(4)(A). The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis.

4) 6) Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this subsection shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by the Illinois Department of Public Health, or the appropriate licensing agency, as a Level I trauma center as required for the adjustment described in subsection (c)(1) above, a Level II trauma center as required for the adjustment described in subsection (c)(2) or (c)(3) above, or as a Level I or a Level II trauma center as required for the adjustment described in subsection (c)(4) above. In these instances, the adjustments calculated under this subsection shall be pro-rated, as applicable, based upon the date that such recognition ceased.

5) 7) Trauma Center Adjustment Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments required by subsection (c) are as follows:

A) "Available funds" means funds which have been deposited into

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the Trauma Center Fund, which have been distributed to the Department by the State Treasurer, and which have been appropriated by the Illinois General Assembly.

B) "Medicaid trauma admission" means those claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under the age of 18.

C) ~~"Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all level II urban trauma centers.~~

~~B)~~ "TCA base period" means State Fiscal Year 1991, for TCA payments calculated for the October 1, 1992 TCA rate period, State Fiscal Year 1992 for TCA payments calculated for the October 1, 1993, TCA rate period, etc.

D) ~~B)~~ "TCA rate period" means, beginning October 1, 1992, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

E) ~~F)~~ "Trauma Center Fund" means the fund created for the purpose of distributing a portion of monies received by county circuit clerks for certain violations of laws or ordinances regulating the movement of traffic to Level I and Level II trauma centers located in the State of Illinois. The Trauma Center Fund shall also consist of all federal matching funds

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received by the Department as a result of expenditures made by the Department as required by subsection (c)(4) above.

~~d) Rehabilitation Hospital Adjustment (RHA)~~

~~Illinois hospitals that, on the first day of July preceding the RHA rate period, qualify as rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2) and are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), shall receive a rehabilitation hospital adjustment in the RHA rate period as follows:~~

~~1) Eligible hospitals, as defined in subsection (c) above, shall receive a rehabilitation hospital adjustment that consists of the following two components:~~

~~A) Treatment Component. All hospitals defined in 89 Ill. Adm. Code 149.50(c)(2) above shall receive $3,800.00 per Medicaid level I admission in the RHA base period.~~

~~B) Facility Component. All hospitals defined in 89 Ill. Adm. Code 149.50(c)(2) above shall receive a facility component that shall be based upon the number of Medicaid level I admissions in the RHA base period as follows:~~

~~i) Hospitals with fewer than 100 Medicaid level I admissions in the RHA base period shall receive a facility component of $100,000.00 in the RHA rate period.~~

~~ii) Hospitals with 100 or more Medicaid level I admissions in the RHA base period shall receive a facility component of $400,000.00 in the RHA rate period.~~

~~2) Each eligible hospital's rehabilitation hospital adjustment for the RHA rate period shall equal the sum of the amounts described in subsections (d)(1)(A) and (d)(1)(B) above. The rehabilitation hospital adjustments shall be paid to eligible hospitals on a quarterly basis.~~

~~3) Rehabilitation Hospital Adjustment Definitions. The definitions of terms used with reference to calculation of the rehabilitation hospital adjustments required by subsection (d) are as follows:~~

~~A) "Medicaid level I admissions" means those claims billed as level I admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the RHA rate period and contained within the Department's paid claims data base, with an occurrence code of 63 when applicable and an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89.~~

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B) "RHA-base-period"-means--State--Fiscal--Year--1991--for--RHA payments--calculated--for--the--October--1,--1992,--RHA-rate period,-State-Fiscal-Year-1992-for-RHA--payments--calculated for-the-October-1,-1993,-RHA-rate-period,-etc.

C) "RHA--rate--period"-means,-beginning-October-1,-1992,-the-12 month-period-beginning-on-October-1-of-the-year--and--ending September-30-of-the-following-year.

e) Perinatal-Center-Adjustments-(PCA)

For--inpatient--admissions--occurring-on-or-after-October-1,-1993,-the Department-shall-make-perinatal-center-adjustments-(PCA)-to--hospitals in-accordance-with-the-provisions-of-subsections-(e)(1)-through-(e)(3) below:

1) Hospitals--that--meet--the--following--criteria--shall-receive-an adjustment-of-$825.00-per-Medicaid-perinatal-admission-in-the-PCA rate-period:

A) The-hospital-is-designated-as-a-level-II-perinatal-center-by the-Illinois-Department-of-Public-Health,-or,-if-applicable, by-the-licensing-agency-in-the-state-in-which--the--hospital is--located,-on-the-first-day-of-July-preceding-the-PCA-rate period;

B) The-hospital-is:

i) With-respect-to-the-October-1,-1992,-PCA-rate--period, located--in--a--rural--area--on--the-first-day-of-July preceding-the-PCA-rate-period;

ii) With-respect-to-the-October-1,-1993,-PCA-rate--period, designated--as-a-rural-hospital,-as-defined-in-Section 148.25(g)(3),-on-July-14,-1993;

iii) With-respect-to-PCA-rate-periods-beginning-on-or-after October-1,-1994,-designated-as-a--rural--hospital,--as defined--in--Section-148.25(g)(3),-on-the-first-day-of July-preceding-the-PCA-rate-period,-and

C) The-hospital-has--a--Medicaid--perinatal--percentage--of--30 percent-or-above.

2) The--perinatal--center--adjustments--calculated--under-subsection (e)(1)-above-shall-be-paid-to-eligible-hospitals-on--a--quarterly basis.

3) Perinatal--Center--Adjustment-Limitations.-Hospitals-that-qualify for-PCA-adjustments-under-subsection-(e)(1)-above--shall--not--be eligible--for--the--total--PCA-adjustment-if,-during-the-PCA-rate period,-the-hospital-is-no-longer-recognized-or-designated-by-the Illinois--Department--of--Public--Health,--or---the---appropriate licensing--agency,-as-a-level-II-perinatal-center,-as-required-by subsection--(e)(1)(A)--above.---In--this--instance,--the---annual adjustment---described---in--subsection--(w)(1)--above--shall--be pro-rated,--as--applicable,--based--upon--the---date---that---the designation-ceased.

4) Perinatal--Center--Adjustment-(PCA)-Definitions.--The-definitions of-terms-used-with-references-to--calculation--of--the--perinatal

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center--adjustments--required--by--this--subsection--(e)--are--as follows:

A) "Medicaid---perinatal---admissions",---as---referred--to--in subsection-(e)(4)(B)-below,-means--those--claims--billed--as admissions,--excluding-admissions-for-normal-newborns,-which were-subsequently-adjudicated-by-the-Department-through--the last-day-of-June-preceding-the-PCA-rate-period-and-contained within--the--Department's-paid-claims-data-base,-for-infants less-than-29-days-of-age-at-the-time-of-the--admission--with an--ICD-9-CM-diagnosis-code-within-the-ranges-of-760-through 779--and--V30--through--V39,--and--those--claims--billed--as admissions,-excluding-admissions-for-normal-newborns,--which were--subsequently-adjudicated-by-the-Department-through-the last-day-of-June-preceding-the-PCA-rate-period-and-contained within-the-Department's-paid-claims-data--base,--related--to pregnancy,--childbirth--and--the-puerperium-with-an-ICD-9-CM principal-diagnosis-code-within-the--range--of--630--through 676.

B) "Medicaid---perinatal--percentage"--means--a--fraction,--the numerator-of-which--is--the--hospital's--Medicaid--perinatal admissions,--and--the-denominator-of-which-is-the-hospital's total-Medicaid-admissions.

C) "PCA-base-period"-means-State--Fiscal--Year--1992,--for--PCA payments--calculated--for--the--October--1,--1993,--PCA-rate period,-State-Fiscal-Year-1993-for-PCA--payments--calculated for-the-October-1,-1994,-PCA-rate-period,-etc.

D) "PCA--rate--period"-means,-beginning-October-1,-1993,-the-12 month-period-beginning-on-October-1-of-the-year--and--ending September-30-of-the-following-year.

E) "Total--Medicaid--admissions",--as-referred-to-in-subsection (e)(4)(B)--above,--means--the---total---claims---billed---as admissions,--excluding-admissions-for-normal-newborns,-which were-subsequently-adjudicated-by-the-Department-through--the last-day-of-June-preceding-the-PCA-rate-period-and-contained within-the-Department's-paid-claims-data-base.

f) Obstetrical-Care-Adjustments-(OCA)

For--inpatient--admissions--occurring-on-or-after-October-1,-1993,-the Department-shall-make-obstetrical-care-adjustments-(OCA)-to--hospitals in-accordance-with-the-provisions-of-subsection-(f)(1)-below:

1) Hospitals--that--meet--the--following--criteria--shall-receive-an adjustment-of-$675.00-per-Medicaid-obstetrical-admission--in--the OCA-rate-period:

A) The-hospital-offers-nonemergency-obstetric-procedures-to-the general--public--on--the-first-day-of-July-preceding-the-OCA rate-period;

B) The-hospital-is:

i) With-respect-to-the-October-1,-1992,-OCA-rate--period, located--in--a--rural--area--on--the-first-day-of-July

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preceding the 0CA rate period;

ii) With respect to the October 1, 1993, 0CA rate period, designated as a rural hospital, as defined in Section 148.25(g)(3), on July 14, 1993;

iii) With respect to 0CA rate periods beginning on or after October 1, 1994, designated as a rural hospital, as defined in Section 148.25(g)(3), on the first day of July preceding the 0CA rate period; and

C) The hospital has a Medicaid obstetrical percentage of 20 percent or above.

2) The obstetrical care adjustments calculated under subsection (f)(1) above shall be paid to eligible hospitals on a quarterly basis.

3) Obstetrical Care Adjustment Limitations. Hospitals that qualify for 0CA adjustments under subsection (f)(1) above shall not be eligible for the total 0CA adjustment if, during the 0CA rate period, the hospital discontinues the provision of non emergency obstetrical care. In this instance, the annual adjustment described in subsection (f)(1) shall be pro rated, as applicable, based upon the date that the hospital discontinued the provision of such non emergency obstetrical care.

4) Obstetrical Care Adjustment (0CA) Definitions. The definitions of terms used with reference to calculation of the obstetrical care adjustments required by subsection (f) are as follows:

A) "Medicaid obstetrical admissions", as referred to in subsection (f)(4)(B) below, means those claims billed as admissions, which were subsequently adjudicated by the Department through the last day of June preceding the 0CA rate period and contained within the Department's paid claims data base, with an ICD 9 CM diagnosis code within the ranges of 650 and 669 which resulted in childbirth.

B) "Medicaid obstetrical percentage" means a fraction, the numerator of which is the hospital's Medicaid obstetrical admissions, and the denominator of which is the hospital's total Medicaid admissions.

C) "0CA base period" means State Fiscal Year 1992, for 0CA payments calculated for the October 1, 1993, 0CA rate period, State Fiscal Year 1993 for 0CA payments calculated for the October 1, 1994, 0CA rate period, etc.

B) "0CA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

E) "Total Medicaid admissions", as referred to in subsection (f)(4)(B) above, means the total claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the 0CA rate period and contained within the Department's paid claims data base.

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g) Targeted Access Payment (TAP) Adjustments

For inpatient admissions occurring on or after October 1, 1993, the Department shall make targeted access payment (TAP) adjustments to Illinois hospitals in accordance with the provisions of subsections (g)(1) through (g)(8) below.

1) Criteria. To qualify for TAP adjustments under this subsection (g), hospitals must meet the following criteria:

A) With respect to the TAP adjustments described in subsections (g)(2) through (g)(6), the hospitals must be eligible to receive the adjustment payments described in Section 148.120(g)(2) in the Tap rate period;

B) With respect to the TAP adjustments described in subsections (g)(2) through (g)(6), the hospital must not be a county owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B);

C) With respect to the TAP adjustments described in subsections (g)(2), (g)(3) and (g)(5), and subject to subsection (g)(1)(E) below, the hospital must have 500 or fewer certificate of need beds if located in an urban area, as described in Section 148.25(g)(4). The number of certificate of need beds shall include total beds, excluding any used for substance abuse and/or long term care beds, and shall be determined by the Illinois Department of Public Health (IDPH), based upon the most current IDPH published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non Federal Hospitals in Illinois", which is available to the Illinois Department of Public Aid in the month immediately preceding the TAP rate period; and

B) With respect to the TAP adjustments described in subsections (g)(2), (g)(3) and (g)(5), and subject to subsection (g)(1)(E) below, the hospital must have 300 or fewer certificate of need beds if located in a rural area, as described in Section 148.25(g)(3). The number of certificate of need beds shall include total beds, excluding any used for substance abuse and/or long term care beds, and shall be determined by the Illinois Department of Public Health (IDPA), based upon the most current IDPH published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non Federal Hospitals in Illinois", which is available to the Illinois Department of Public Aid in the month immediately preceding the TAP rate period.

B) Notwithstanding the provisions of subsections (g)(1)(C) and (g)(1)(B), a children's hospital, as described in 148.120(a)(5), shall be eligible for the adjustments

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described in subsections (g)(2) and (g)(4). A children's hospital shall not be subject to or eligible for the adjustments described in subsections (g)(3), (g)(5) or (g)(6).

F) Effective August 1, 1994, subsections (g)(1)(C) and (g)(1)(D) above shall not apply.

2) Medicaid Percentage Adjustment. Eligible hospitals, as described in subsection (g)(1) above, with a Medicaid inpatient utilization rate, as defined in Section 148.120(i)(5), of 35% or above shall receive an adjustment of $70.00 per Medicaid admission in the PAP base year and all other eligible hospitals shall receive an adjustment per Medicaid admission in the PAP base year which is calculated by dividing the individual hospital's Medicaid inpatient utilization rate by 35% and multiplying the result by $70.00.

3) Obstetrical Care Adjustment. Eligible hospitals, as described in subsection (g)(1) above, that provide nonemergency obstetrical services to the general public shall receive a PAP obstetrical care adjustment which shall include:

A) An adjustment of $680.00 per Medicaid obstetrical admission in the PAP base period; and

B) An additional adjustment, up to $340.00 per Medicaid obstetrical admission in the PAP base period, based upon the hospital's Medicaid obstetrical admission percentage. The additional adjustment shall be calculated by giving the hospital providing the most Medicaid obstetrical admissions a $340.00 adjustment per Medicaid obstetrical admission in the PAP base period and all other qualifying hospitals an adjustment equal to the individual hospital's Medicaid obstetrical admission percentage divided by the Medicaid obstetrical admission percentage of the hospital with the highest Medicaid obstetrical admission percentage, the result of which shall then be multiplied by $340.00.

4) Children's Care Adjustment. Eligible hospitals, as described in subsections (g)(1)(A) through (g)(1)(B) above, that provide services to children (defined as under the age of 18 and which excludes obstetrical services) shall receive a PAP children's care adjustment.

A) Eligible hospitals, as described in subsections (g)(1)(A), (g)(1)(B), and (g)(1)(E) above, shall receive a PAP children's care adjustment of up to $600.00 per Medicaid children's admission in the PAP base period. The adjustment shall be calculated by dividing each eligible hospital's Medicaid children's admissions in the PAP base period by each eligible hospital's total Medicaid admissions in the PAP base period to arrive at the Medicaid children's admission percentage.

B) The hospital with the highest percentage of Medicaid

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children's admissions shall receive an adjustment of $600.00 for each Medicaid children's admission in the PAP base period and all other qualifying hospitals shall receive an adjustment equal to $600.00 multiplied by the individual hospital's Medicaid children's admission percentage divided by the Medicaid children's admission percentage of the hospital with the highest Medicaid children's admission percentage.

5) Ambulatory Care Network Adjustment. Eligible hospitals, as described in subsection (g)(1) above, shall complete and submit the Ambulatory Care Network Questionnaire in order to be considered for the PAP ambulatory care network adjustment. The Ambulatory Care Network Questionnaire must be received within 30 calendar days after receipt of notification from the Department that the information must be submitted. Information required in this subsection (g) which is not received in compliance with this requirement shall not be considered for the determination of those hospitals qualified for ambulatory care network adjustments. In addition, such hospitals shall be required to enter into an agreement with the Department which describes in detail their involvements in ambulatory care, and includes commitments to maintain operations. Hospitals shall be required to notify the Department in advance of any action which would result in a reduction of 20 percent or more in the number of visits provided by hospital operated primary care clinics or a reduction of 20 percent or more in the number of visits provided by primary care physicians. The PAP ambulatory care network adjustment shall consist of three possible individual adjustments as follows:

A) Hospitals reporting the following number of physician office visits on the Ambulatory Care Network Questionnaire shall receive the following adjustments per total Medicaid admissions in the PAP base period:

Urban Threshold	Rural Threshold	Adjustment
0 - 9,999	0 - 4,999	$ 00.00
10,000 - 40,000	5,000 - 10,000	$125.00
40,001 - 100,000	10,001 - 50,000	$145.00
100,001 and over	50,001 and over	$165.00

B) Hospitals qualifying for an adjustment under subsection (g)(5)(A) above shall receive an additional $135.00 per total Medicaid admissions in the PAP base period if they have a formal linkage agreement with City of Chicago Partnerships in Health or Medicaid Partnerships.

C) Hospitals qualifying for an adjustment under subsection (g)(5)(A) above shall receive an additional $135.00 per total Medicaid admissions in the PAP base period if they

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have a formal linkage agreement with a Federally Qualified Health Center, a County Health Clinic, or a Rural Health Clinic.

6) TAP - Index - Adjustment. With the exception of adjustments calculated in subsections (g)(2) and (g)(4) for children's hospitals as described in Section 148.120(a)(5), the sum of the adjustments calculated in subsections (g)(2) through (g)(5) shall be multiplied by the following applicable percentages, which are based upon each hospital's Medicaid inpatient utilization rate as defined in Section 148.120(b)(5):

A) For those hospitals with a Medicaid inpatient utilization rate of 45 percent or above, the applicable percentage is 110 percent.

B) For those hospitals with a Medicaid inpatient utilization rate of at least 25 percent, but less than 45 percent, the applicable percentage is 50 percent.

C) For those hospitals with a Medicaid inpatient utilization rate of less than 25 percent, the applicable percentage is 25 percent.

7) The TAP adjustments calculated under subsections (g)(2) through (g)(6) above shall be paid to eligible hospitals on a quarterly basis.

8) Targeted Access Payment Adjustment Limitations. Hospitals that qualify for TAP adjustments under subsection (g)(3) above shall not be eligible for the total TAP adjustment if, during the TAP rate period:

A) The hospital discontinues the provision of non-emergency obstetrical care. In this instance, the annual adjustment described in subsections (g)(3) and (g)(6) shall be pro-rated, as applicable, based upon the date that the hospital discontinued the provision of such non-emergency obstetrical care.

B) The hospital does not honor its commitment to maintain operations as required in subsection (g)(5) of this Section. In the event that there is a reduction of 20 percent or more in the number of visits provided by hospital operated primary care clinics or a reduction of 20 percent or more in the number of visits provided by primary care physicians, the Department may, subject to approval by the Director, deem the hospital ineligible for the adjustments described in subsections (g)(5) and (g)(6) of this Section, either in total or in part.

C) The hospital discontinues its formal linkage agreements required in subsections (g)(5)(B) and (g)(5)(C). In this instance, the annual adjustment described in subsections (g)(5) and (g)(6) shall be pro-rated based upon the date that the formal linkage agreement(s) was discontinued.

9) Targeted Access Payment (TAP) Adjustment Definitions. The

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definitions of terms used with reference to calculation of the targeted access payment adjustments made by subsection (g) are as follows:

A) "Medicaid children's admission" means those claims billed as admissions of an individual under age 1, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of the month preceding the TAP rate period and contained within the Department's paid claims data base, but excludes those claims billed as admissions with an ICD-9-CM principal diagnosis code within the range of 630 and 669 (indicating an obstetrical admission).

B) "Medicaid inpatient admission" means those claims billed as admissions, which were subsequently adjudicated by the Department through the last day of the month preceding the TAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code within the ranges of 001 and 629 which resulted in childbirth.

C) "Medicaid obstetrical admission percentage" means a fraction, the numerator of which is the hospital's Medicaid obstetrical admissions, and the denominator of which is the Medicaid obstetrical admissions provided by all hospitals qualified for the TAP obstetrical care adjustment.

D) "Medicaid perinatal percentage" means a fraction, the numerator of which is the hospital's Medicaid perinatal admissions, and the denominator of which is the hospital's total Medicaid admissions.

E) "TAP base period" means State Fiscal Year 1992, for TAP payments calculated for the October 1, 1993, TAP rate period; State Fiscal Year 1993, for TAP payments calculated for the October 1, 1994, TAP rate period; etc.

F) "TAP rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

G) "Total Medicaid admissions", as referred to in subsection (g)(9)(B), means the total claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of the month preceding the TAP rate period and contained within the Department's paid claims data base.

d) Medicaid High Volume Adjustments (MHVA)

1) For inpatient admissions occuring on or after October 1, 1993, the Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals in accordance with the provisions of subsection (h)(1) through (h)(2) below. 1) Criteria. To qualify for MHVA adjustments under this subsection (h), hospitals must that meet the following criteria:

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~~A) With respect to the MHVA described in subsection (h)(2)(A) through (h)(2)(C), the hospitals must:~~

~~A)~~ ~~i)~~ Be eligible to receive the adjustment payments described in Section 148.120 in the MHVA rate period; and

~~B)~~ ~~ii)~~ Not be a county-owned hospital, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B) in the MHVA rate period~~.~~ ; and

C) Not be a facility operated by the Department of Mental Health and Developmental Disabilities, as described in Section 148.25(b)(6).

~~B) With respect to the MHVA adjustments described in subsection (h)(2)(B):~~

~~i) The hospital must not be eligible to receive the adjustment payments described in Section 148.120(g)(2) in the MHVA rate period;~~

~~ii) The total number of Medicaid inpatient days as defined in subsection (h)(4)(B) of this Section, provided by each Medicaid participating Illinois hospital, must be at least one standard deviation above the mean number of Medicaid inpatient days, as defined in subsection (h)(4)(A) of this Section for the MHVA base fiscal year; and~~

~~iii) The hospital must meet the requirements of subsection (h)(1)(B) below when located in a geographic area covered by the managed care component of the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 148.928(a)(1);~~

~~C) Source of Data. In making the determination described in subsection (h)(1)(B)(ii) above, the Department shall utilize:~~

~~i) The hospital's final audited cost report for the hospital's MHVA base fiscal year. Medicaid inpatient days, as defined in subsection (h)(4)(B) of this Section, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation;~~

~~ii) In the absence of a final audited cost report for the hospital's MHVA base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's MHVA base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsection (h)(1)(B)(ii) above. Submittal of a corrected cost report in support of subsection (h)(1)(B)(ii) above must be received no later than the first day of July preceding the MHVA rate period for which the hospital is requesting consideration of such corrected cost report for the determination of MHVA qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's Medicaid inpatient days as described in subsection (h)(4)(B) of this Section;~~

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~~iii) Hospitals' Medicaid inpatient days, as defined in subsection (h)(4)(B) of this Section, which have been derived from unaudited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsection (h)(1)(C)(ii) above, hospitals shall have the opportunity to submit corrected cost report information prior to the Department's MHVA determination;~~

~~iv) In the event a subsequent final audited cost report reflects Medicaid inpatient days, as described in subsection (h)(4)(B) of this Section, which are lower than the Medicaid inpatient days derived from the unaudited cost report utilized for the MHVA determination, the Department shall recalculate the Medicaid inpatient days based upon the final audited cost report, and recoup any overpayments made;~~

~~B) Hospitals meeting the criteria described in subsection (h)(1)(B) above, that are located in a geographic area covered by the managed care component of the Healthy Moms/Health Kids Program, as described in 89 Ill. Adm. Code 148.928(a)(1), must meet the following requirements:~~

~~i) Hospitals designated as Level III perinatal centers by the Illinois Department of Public Health must enter into an agreement with the Department to participate in the Healthy Moms/Healthy Kids Program as a Certified Obstetrical Ambulatory Care Center (COBACC), as described in 89 Ill. Adm. Code 148.46(f)(1)(C), with a minimum Healthy Moms/Healthy Kids client assignment capacity commitment that includes a specified minimum number of pregnant women determined to be at medical high risk of abnormal delivery and as otherwise mutually agreeable to both the Department and the hospital;~~

~~ii) Hospitals that are not designated as Level III perinatal centers by the Illinois Department of Public Health must enter into an agreement or agreements with the Department to participate in the Health Moms/Healthy Kids Program as a Certified Hospital Ambulatory Primary Care Center (CHAPCC), as described~~

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~~in--89--Ill.--Adm.--Code--140.461(f)(1)(A),--and/or--a Certified-Hospital-Organized-Satellite-Clinic-(CHOSC), as--described--in--89-Ill.-Adm.-Code-140.461(f)(1)(B), with-a-minimum-total-Healthy-Moms/Healthy-Kids--client assignment---capacity--commitment--that--is--otherwise mutually-agreeable-to--both--the--Department--and--the hospital;-and~~

~~iii) Hospitals--must-enter-into-the-agreements-described-in subsections-(h)(1)(B)(ii)-and--(h)(1)(B)(iii)--above--by the-first-day-of-January-in-the-MHVA-rate-period.~~

2) Calculation of Medicaid High Volume Adjustments

A) Hospitals meeting the criteria specified in subsection (d)(1) ~~(h)(1)(A)~~ above shall receive a MHVA payment adjustment of $60.

B) For children's hospitals, as defined in Section 148.120(a)(5), the payment adjustment calculated under subsection (d)(2)(A) ~~(h)(2)(A)~~ above shall be multiplied by 2.0.

C) The amount calculated pursuant to subsections (d)(2)(A) ~~(h)(2)(A)~~ and (d)(2)(B) ~~(h)(2)(B)~~ above shall be adjusted on October 1, 1993, and annually thereafter, by a percentage equal to the lesser of:

i) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent twelve month period for which data are available; or

ii) The percentage increase in the statewide average hospital payment rate, as described in subsection (d)(4)(C) ~~(h)(4)(E)~~ of this Section, over the previous year's statewide average hospital payment rate.

~~B) Hospitals--meeting--the--criteria--specified--in-subsections (h)(1)(B)--and--(h)(1)(B)--above--shall--receive--an--add-on payment-to-their-inpatient-rate.~~

~~i) The--distribution--method--for--the---add-on---payment described--in-subsection-(h)(2)(B)-above-is-based-upon a-fund-of-$12-million.--All-hospitals-qualifying-under subsections-(h)(1)(B)-and-(h)(1)(B)-above-will-receive an-$85-per-day-add-on--to--their--current--rate.---The total---cost--of--this--adjustment--is--calculated--by multiplying--each--hospital's--most--recent--completed fiscal--year--Medicaid--inpatient---utilization---data (adjusted---based---upon--historical--utilization--and projected-increases-in-utilization)-by-$85.--The-total dollar-amount-of-this-calculation-is--then--subtracted from-the-$12-million-fund.~~

~~ii) The--remaining-fund-balance-is-then-distributed-to-the hospitals-that-are--located--in--a--geographical--area covered--by--the-managed-care-component-of-the-Healthy Moms/Healthy-Kids-Program-as-described-in-89-Ill.-Adm. Code-140.928(e)(1)-in-proportion-to-the-percentage--by which--the--hospital's--Medicaid--inpatient--days--as described---in---subsection---(h)(4)(B),--exceeds--one standard-deviation-above--the--State's--mean--Medicaid inpatient--days,--as-described-in-subsection-(h)(4)(A) of-this-Section.--This-is-done-by-finding-the-ratio-of each-qualified-hospital's-percent--Medicaid--inpatient days--to--the-State's-mean-plus-one-standard-deviation percent-Medicaid-inpatient-days-value.---These--ratios are---then---summed---and--each--qualified--hospital's proportion--of--the--total---is---calculated.----These proportional---values--are--then--multiplied--by--each qualified-hospital's-most-recent-completed-fiscal-year Medicaid-inpatient-utilization--data--(adjusted--based upon-historical-utilization-and-projected-increases-in utilization).----These--weighted--values-are-summed-and each-qualified-hospital's--proportion--of--the--summed weighted---value---is---calculated.---Each--individual qualified--hospital's--proportional--value---is---then multiplied--against--the--$12--million--pool--of-money available-after-the-$85-per-day-base-add-on--has--been subtracted.~~

~~iii) The-total-dollar-amount-calculated-for-each-qualifying hospital--under--subsection--(h)(2)(B)(ii)-above-(plus the-initial-$85-per-day-add-on-amount--calculated--for each-qualifying-hospital-under-subsection-(h)(2)(B)(ii) above)--is--then--divided--by--the--Medicaid-inpatient utilization--data--(adjusted--based--upon---historical utilization-and-projected-increases-in-utilization)-to arrive--at--a-per-day-add-on-value.--Hospitals-meeting the-criteria-described-under-subsection-(h)(1)(B)(ii), that-are-not-located-in-a-geographical-area-covered-by the-managed-care-component-of-the-Healthy-Moms/Healthy Kids-Program,--as--described--in--89--Ill.--Adm.--Code 140.928(e)(1),--will-receive-the-minimum-adjustment-of $85-per-inpatient--day.----The--adjustments--calculated under--this--subsection-are-subject-to-the-limitations described-in-subsection-(h)(3)-below.-The--adjustments calculated--under--this--subsection-are-subject-to-the limitations-described-in-subsection-(h)(3)-below.~~

D)B) The adjustments calculated under subsections (d)(2)(A) ~~(h)(2)(A)~~ through (d)(2)(C) ~~(h)(2)(B)~~ of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.

3) Medicaid High Volume Adjustment Limitations.

~~A) Hospitals-located--in--a--geographic--area--covered--by--the managed--care--component--of--the--Healthy-Moms/Healthy-Kids~~

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~~Program, as described in 89 Ill. Adm. Code 148.920(a)(1), that qualify for MHVA adjustments under subsection (h)(2)(B) above, shall not be eligible for the MHVA adjustment if:~~

~~i) The hospital does not enter into a Healthy Moms/Healthy Kids agreement, as required in subsections (h)(1)(B)(i) and (h)(1)(B)(ii) above, by the first day of January of the MHVA rate period. In this instance, any adjustments described in subsection (h)(2)(B) that have been made by the Department shall be recouped and the hospital shall no longer be deemed eligible for the MHVA adjustment.~~

~~ii) The hospital does not honor its minimum Healthy Moms/Healthy Kids client assignment capacity commitment as described in subsections (h)(1)(B)(i) and (h)(1)(B)(ii) of this Section. In this instance, the Department may, subject to approval by the Director, deem the hospital ineligible for the adjustments described in subsection (h)(2)(B) of this Section, either in total or in part.~~

B) Hospitals that qualify for MHVA adjustments under subsections (d)(2)(A) ~~(h)(2)(A)~~ through (d)(2)(C) ~~(h)(2)(C)~~ above shall not be eligible for such MHVA adjustments if they are no longer recognized or designated by the Department as a DSH hospital, as required by subsection (d)(1) ~~(h)(1)(A)(i)~~. In this instance, the annual adjustment described in subsections (d)(2)(A) ~~(h)(2)(A)~~ through (d)(2)(C) ~~(h)(2)(C)~~ shall be pro-rated, as applicable, based upon the date that the hospital was deemed ineligible for DSH payments adjustments, under Section 148.120, by the Department.

~~C) In no instance shall the final aggregate MHVA payment adjustments calculated under subsection (h)(2)(B)(i) above for all hospitals exceed $12 million. In the event that aggregate MHVA payment adjustments calculated under subsection (h)(2)(B)(i) exceed $12 million, each hospital's MHVA payment adjustment calculated under subsection (h)(2)(B)(i) above shall be adjusted proportionately to ensure that the final aggregate MHVA payment adjustments calculated under subsection (h)(2)(B)(i) above for all hospitals do not exceed $12 million.~~

4) Medicaid High Volume Adjustment Definitions. The definitions of terms used with reference to calculation of the MHVA adjustments required by subsection (d) ~~(h)~~ are as follows:

~~A) "Mean Medicaid inpatient days" means a fraction the numerator of which is the total number of inpatient days provided in a given 12 month period by all Medicaid participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX under the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.) and the denominator of which is the total number of all Medicaid participating Illinois hospitals. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Section 148.120(c)(3). In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.~~

B) "MHVA base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, MHVA determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, MHVA determination year, etc.

B)~~C)~~ "MHVA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

~~B) "Medicaid inpatient days" means the total number of inpatient days provided in a given 12 month period by each hospital to patients who, for such days, were eligible for Medicaid under Title XIX under the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.). Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Section 148.120(c)(3). In this subsection (h)(4)(B), the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.~~

C)~~E)~~ "Statewide Average Hospital Payment Rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).

e)~~i)~~ Inpatient Payment Adjustments based upon Reviews. Appeals based upon a hospital's ineligibility for the inpatient payment adjustments described in this Section, or their payment adjustment amounts, in accordance with Section 148.310, which result in a change in a hospital's eligibility for inpatient payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the inpatient payment adjustments of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for inpatient payment adjustments based upon the requirements of this Section.

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~~f)~~j~~)~~ Reductions to Total Payments

1) Copayments. Copayments are assessed under all medical programs administered by the Department except the Children and Family Assistance Program, formerly known as the General Assistance medical program and shall be assessed in accordance with Section 148.190.

2) Third Party Payments. Hospitals shall determine that services are not covered, in whole or in part, under any program or under any other private group indemnification or insurance program, health maintenance organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 148.310 Review Procedure

a) Inpatient Rate Reviews

1) Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of the rate for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of their rates. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) Hospitals reimbursed in accordance with Sections 148.250 through 148.300 and 89 Ill. Adm. Code 149 with respect to per diem add-ons for capital~~,--medical--education--and--CRNA--costs~~, may request that an adjustment be made to their base year costs to reflect significant changes in costs which have been mandated in order to meet State, federal or local health and safety standards, and which have occurred since the hospital's filing of the base year cost report. The allowable Medicare/Medicaid costs must be identified from the most recent audited cost report available. These costs must be significant, i.e., on a per unit basis, they must constitute one percent or more of the total allowable Medicaid/Medicare unit costs for the same time period. Appeals for base year cost adjustments must be received, in writing, by the Department within 30 days after the date of the Department's notice to the hospital of their rates. Such request shall include a clear explanation of the cost change and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

~~3) Primary--Care--Access--Health--Care--Education--Payment--Reviews.~~

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~~Hospitals--reimbursed--in--accordance--with--89--Ill.--Adm.--Code 149.140,--with--respect--to-per-discharge-add-ons-for-primary-care access-health-care-education-payments,-shall:~~

~~A) Be-notified-of-their-per-discharge--add-on--amount--for--the rate--period--and--shall--have--an--opportunity-to-request-a review-of-the-per-discharge--add-on--amount--for--errors--in calculation.---Such-a-request-must-be-received-in-writing-by the--Department--within--30--days--after--the--date--of--the Department's-notice-to-the-hospital-of-their--per--discharge add-on---amount.----Such---request--shall--include--a--clear explanation-of-the-reason-for-the-appeal--and--documentation of--the-desired-correction.--The-Department-shall-notify-the hospital-of-the-results-of-the-review-within-30--days--after receipt-of-the-hospital's-request-for-review.~~

~~B) Be--notified--of-any-adjustments-that-shall-be-made-to-their per-discharge-add-on-amount-for-the-rate-period-as-a--result of--the-requirements-of-89-Ill.-Adm.-Code-149.140,-and-shall have-an-opportunity-to-request-a-review-of--such--adjustment determinations--for--errors--in-calculation.--Such-a-request must-be-received-in-writing-by-the-Department-within-30-days of-the-date-of-the-Department's-notice-to--the--hospital--of adjustment--amounts.---Such--a-request-shall-include-a-clear explanation-of-reason-for-the-appeal--and--documentation--of the--desired--correction.---The--Department-shall-notify-the hospital-of-the-results-of-the-review-within-30--days--after receipt-of-the-hospital's-request-for-review.~~

b) DSH Determination Reviews

1) Hospitals shall be notified of their qualification for DSH payment adjustments and shall have an opportunity to request a review of the DSH add-on for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of its disproportionate share qualification and add-on calculations. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) DSH determination reviews shall be limited to the following:

A) DSH Determination Criteria. The criteria for DSH determination shall be in accordance with Section 148.120. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.

B) Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120 (1)(5). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

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C) Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act and Section 148.120(a)(2) and (d). Review shall be limited to verification that low income utilization rates were calculated in accordance with federal and State regulations.

D) Federally Designated Health Manpower Shortage Areas (HMSAs). Illinois hospitals located in federally designated HMSAs shall be identified in accordance with 42 CFR 5, (1989), and Section 148.120(a)(3) based upon the methodologies utilized by, and the most current information available to the Department from the Department of Health and Human Services as of June 30, 1992. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HMSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA as of June 30, 1992.

E) Excess Beds. Excess bed information shall be determined in accordance with Public Act 86-268 Code Section 148.120(a)(3) and 77 Ill. Adm. Code 1100) based upon the methodologies utilized by, and the most current information available to, the Illinois Health Facilities Planning Board as of July 1, 1991. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and utilized by the Department was incorrect.

F) Medicaid Obstetrical Inpatient Utilization Rates. Medicaid obstetrical inpatient utilization rates shall be calculated in accordance with Section 148.120(a)(4), (l)(4), (l)(6) and (l)(7). Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with State regulations.

c) Outlier Adjustment Reviews

The Department shall make outlier adjustments to payment amounts in accordance with 89 Ill. Adm. Code 149.105 or Section 148.130, whichever is applicable. Hospitals shall be notified of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review of such specific information for errors in calculation only. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review

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within 30 days after receipt of the hospital's request for review.

d) Cost Report Reviews

1) Cost reports are required from:

A) All enrolled hospitals within the State of Illinois;

B) All out-of-state hospitals providing 100 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program; and

C) All hospitals not located in Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the DRG PPS).

2) The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days of the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report which may contain adjustments and revisions which may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis which support the request for review. No additional data shall be accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

~~e) Uncompensated-Care-Adjustment-Reviews~~

~~The-Department-shall-make-uncompensated-care-adjustments-in-accordance with-Section-148.150.--Hospitals-shall-have-the-right--to--appeal--the uncompensated--care--rate--calculation--or-their-ineligibility-for-the uncompensated-care-rate-adjustment-if-it-is-believed-that-a--technical error-has-been-made-in-the-calculation.--The-appeal-must-be-in-writing and--must--be--received-within-30-days-after-the-date-the-Department's notice-to-the-hospital-of-its--qualification--for--uncompensated--care payment--adjustment--amounts,--or--a--letter--of-notification-that-the hospital--does--not--qualify--for--the--uncompensated---care---payment adjustment.---The--Department-shall-notify-the-hospital-of-the-results of-the-review-within-30-days-after-receipt-of-the--hospital's--request for-review.~~

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e)~~f)~~ Trauma Center Adjustment Reviews

1) The Department shall make trauma care adjustments in accordance with Section 148.290(c). Hospitals shall have the right to appeal the trauma center adjustment calculations if it is believed that a technical error has been made in the calculation.

2) ~~Illinois hospitals located in federally designated HMSAs shall be identified in accordance with 42 CFR 5, 1989, based upon the methodologies utilized by, and the most current information available to, the Department from the Department of Health and Human Services as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HMSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA as of the first day of July preceding the trauma center adjustment rate period.~~

~~3)~~ Trauma level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating that the information supplied to and utilized by the Department was incorrect.

3)~~4)~~ Appeals under this subsection (e) ~~(f)~~ must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

~~g) Rehabilitation Hospital Adjustment Reviews~~

~~The Department shall make rehabilitation hospital adjustments in accordance with Section 148.290(d). Hospitals shall have the right to appeal the rehabilitation hospital adjustment calculations if it is believed that a technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for rehabilitation hospital adjustments and payment adjustment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.~~

~~h) Perinatal Center Adjustment Reviews~~

~~1) Medicaid Perinatal Percentage. Medicaid perinatal percentage~~

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~~shall be calculated in accordance with Section 148.290(e). Review shall be limited to verification that perinatal percentages were calculated in accordance with State regulations.~~

~~2) Perinatal level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the perinatal center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating that the information supplied to and utilized by the Department was incorrect.~~

~~3) Appeals under this subsection (h) must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for perinatal center adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~i) Medicaid Obstetrical Care Adjustment Review~~

~~Medicaid Obstetrical Percentage. Medicaid obstetrical percentage shall be calculated in accordance with Section 148.290(f). Review shall be limited to verification that Medicaid obstetrical percentages were calculated in accordance with State regulations. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for obstetrical care adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~j) PAP Adjustments~~

~~1) Medicaid Percentage. Medicaid inpatient utilization rates shall be calculated in accordance with Section 148.120(i)(5). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with State regulations.~~

~~2) Medicaid Obstetrical Admission Percentage. Medicaid obstetrical admission percentage shall be calculated in accordance with Section 148.290(g)(3). Review shall be limited to verification that Medicaid obstetrical admission percentages were calculated in accordance with State regulations.~~

~~3) Medicaid Children's Admission Percentage. Medicaid children's admission percentage shall be calculated in accordance with Section 148.290(g)(4). Review shall be limited to verification that Medicaid children's admission percentages were calculated in accordance with State regulations.~~

~~4) PAP Bed limits. The PAP bed limits described in Section~~

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~~148.290(g)(1)(C) and (g)(1)(D) shall be determined in accordance with such subsections, and review shall be limited to verification that these PAP bed limits were determined in accordance with such subsections.~~

~~5) Appeals under subsection (j) of this Section must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for targeted access adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

f)~~k)~~ Medicaid High Volume Adjustment Reviews

The Department shall make Medicaid high volume adjustments in accordance with Section 148.290(d) ~~148.290(h)~~. Review shall be limited to verification that the Medicaid inpatient days were calculated in accordance with State regulations. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment adjustment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

g)~~l)~~ Sole Community Hospital Designation Reviews

The Department shall make sole community hospital designations in accordance with 89 Ill. Adm. Code 149.125(b). Hospitals shall have the right to appeal the designation if it believes that a technical error has been made in the determination. The appeal must be made in writing and must be received within 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

h)~~m)~~ Geographic Designation Reviews

1) The Department shall make rural hospital designation in accordance with Section 148.25(g)(3). Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received within 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

2) The Department shall make urban hospital designations in accordance with Section 148.25(g)(4). Hospitals shall have the

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right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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1) Heading of the Part: Medical Payment

2) Code Citation: 89 Ill. Adm. Code 140

3) Section Numbers: Proposed Action:

140.80	Amendment
140.82	Amendment
140.84	Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, par. 12-13) [305 ILCS 5/12-13]

5) Complete Description of the Subjects and Issues Involved: These proposed amendments pertain to the Department's provider assessment program for hospitals, facilities for persons with developmental disabilities and nursing homes. Changes are being proposed to exempt facilities operated by the Department of Mental Health and Developmental Disabilities (DMHDD) from assessment responsibility, to comply with Public Act 88-554 which created the University of Illinois Fund, and to make certain clarifications regarding due dates in the assessment program.

Some of the proposed amendments to Section 140.80 correspond to emergency rulemakings, effective March 1, 1995, at 89 Ill. Adm Code 148 and Section 140.80. These emergency rulemakings respond to a Department initiative enabling Illinois to maximize federal financing benefits to hospitals as permitted by the State's federal disproportionate share (DSH) spending limitations. According to the emergency changes in Part 148, facilities operated by DMHDD will be eligible to qualify for DSH hospital payment adjustments. The emergency changes in Section 140.80 exempt facilities operated by DMHDD from the hospital provider assessment program. The Department assesses hospitals to increase State revenue. To tax another State entity would simply be transferring dollars from one State entity to another with no net increase in revenue. The DMHDD facilities are now considered as providers of hospital services which qualify for DSH adjustments, and must be specifically exempted from the hospital assessments imposed under Section 140.80. Proposed amendments to Section 140.80 regarding DSH payment adjustments for facilities operated by DMHDD are identical to the emergency amendments to that Section, and upon adoption will assure the exemption of DMHDD facilities from assessment responsibility following expiration of the emergency provisions.

Proposed changes are being made to Section 140.80 to comply with Public Act 88-554, which created the University of Illinois Fund. These changes pertain to hospitals organized under the University of Illinois Hospital Act which are exempt from the provider assessments imposed by Section 140.80. Previously, the interagency agreement between the Department and such hospitals provided for intergovernmental transfer payments to the

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Department which were deposited into the State's General Revenue Fund. According to changes under Public Act 88-554, intergovernmental transfer payments from the University of Illinois Hospital are to be deposited into the University of Illinois Fund.

Other proposed changes are being made to Sections 140.80, 140.82 and 140.84 to accommodate calendar changes from one fiscal year to another. The provider assessment program described in these Sections was initially effective for fiscal year 1994 and dates specified in the rules as due dates for payment of assessments and dates specified for Department receipt of delayed payment requests from providers, are no longer accurate. Therefore, the rules are being revised to indicate that providers will be notified in writing by the Department of applicable dates for each fiscal year.

Proposed changes are also being made to Section 140.84 to clarify that only skilled nursing and intermediate care licensed beds in nursing homes are subject to payment responsibility under the provider assessment program. Beds in nursing homes which are specifically designated for sheltered care purposes are not subject to assessments.

These proposed amendments will not result in any budgetary changes for the Department.

6) Will these proposed amendments replace emergency amendments currently in effect? Some of the proposed amendments in Section 140.80 will replace emergency amendments which were effective March 1, 1995, and are to be published on March 17, 1995. The proposed amendments which will replace emergency amendments pertain to facilities operated by the Department of Mental Health and Developmental Disabilities and their eligibility for receiving disproportionate share payment adjustments. These changes are fully described above in the complete description of the subjects and issues involved.

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? Yes

Sections	Proposed Action	Illinois Register Citation
140.11	Amendment	January 13, 1995 (19 Ill. Reg. 165)
140.12	Amendment	January 13, 1995 (19 Ill. Reg. 165)
140.400	Amendment	February 10, 1995 (19 Ill. Reg. 1200)
140.413	Amendment	July 8, 1994 (18 Ill. Reg. 10637)
140.435	Amendment	February 10, 1995 (19 Ill. Reg. 1200)
140.523	Amendment	January 13, 1995 (19 Ill. Reg. 165)

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140.645 Amendment December 16, 1994 (18 Ill. Reg. 17865)

10) Statement of Statewide Policy Objectives: These proposed amendments do not affect units of local government.

11) Time, Place, and Manner in which Interested Persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to Joanne Jones, Bureau of Rules and Regulations, Illinois Department of Public Aid, 100 South Grand Ave. E., 3rd Floor, Springfield, Illinois 62762 (Phone: (217) 524-3215). The Department requests the submission of written comments within 30 days after the publication of this notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

These proposed amendments may have an impact on small businesses, small municipalities, and not for profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not for profit corporations as part of any written comments they submit to the Department.

Any interested persons may review these amendments at the Department of Public Aid's local offices located in each county (except Cook County). In Cook County, the amendments may be reviewed at the Office of the Director, Illinois Department of Public Aid, 310 South Michigan Avenue, Suite 1700, Chicago, Illinois. The amendments may be reviewed at all offices Monday through Friday from 8:30 A.M. until 5:00 P.M. These copies of the amendments are being made available for review in accordance with federal requirements at 42 CFR 447.205.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Hospitals, nursing homes, and long term care facilities for persons with developmental disabilities

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

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13) State reasons for this rulemaking if it was not included in either of the two most recent regulatory agendas: The reasons for this rulemaking are fully described above in the complete description of the subjects and issues involved. This rulemaking was not anticipated by the Department when the most recent regulatory agenda was published.

14) State reason(s) for this rulemaking if it was not in either of the two (2) most recent regulatory agendas:

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 140
MEDICAL PAYMENT

SUBPART A: GENERAL PROVISIONS

Section
140.1 Incorporation By Reference
140.2 Medical Assistance Programs
140.3 Covered Services Under The Medical Assistance Programs for AFDC, AFDC-MANG, AABD, AABD-MANG, RRP, Individuals Under Age 18 Not Eligible for AFDC, Pregnant Women Who Would Be Eligible if the Child Were Born and Pregnant Women and Children Under Age Eight Who Do Not Qualify as Mandatory Categorically Needy and Disabled Persons Under Age 21 Who May Qualify for Medicaid and In-Home Care (Model Waiver)
140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
140.5 Covered Medical Services Under GA
140.6 Medical Services Not Covered
140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
140.8 Medical Assistance For Qualified Severely Impaired Individuals
140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
140.10 Medical Assistance Provided to Incarcerated Persons

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section
140.11 Enrollment Conditions for Medical Providers
140.12 Participation Requirements for Medical Providers
140.13 Definitions
140.14 Denial of Application to Participate in the Medical Assistance Program
140.15 Recovery of Money
140.16 Termination or Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.18 Effect of Termination on Individuals Associated with Vendor
140.19 Application to Participate or for Reinstatement Subsequent to Termination, Suspension or Barring
140.20 Submittal of Claims
140.21 Covered Medicaid Services for Qualified Medicare Beneficiaries (QMBs)

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140.22 Magnetic Tape Billings
140.23 Payment of Claims
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140.25 Overpayment or Underpayment of Claims
140.26 Payment to Factors Prohibited
140.27 Assignment of Vendor Payments
140.28 Record Requirements for Medical Providers
140.30 Audits
140.31 Emergency Services Audits
140.32 Prohibition on Participation, and Special Permission for Participation
140.33 Publication of List of Terminated, Suspended or Barred Entities
140.35 False Reporting and Other Fraudulent Activities
140.40 Prior Approval for Medical Services or Items
140.41 Prior Approval in Cases of Emergency
140.42 Limitation on Prior Approval
140.43 Post Approval for items or Services When Prior Approval Cannot Be Obtained
140.71 Reimbursement for Medical Services Through the Use of a C-13 Invoice Voucher Advance Payment and Expedited Payments
140.72 Drug Manual (Recodified)
140.73 Drug Manual Updates (Recodified)

SUBPART C: PROVIDER ASSESSMENTS

Section
140.80 Hospital Provider Fund
140.82 Developmentally Disabled Care Provider Fund
140.84 Long Term Care Provider Fund
140.94 Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund
140.95 Hospital Services Trust Fund
140.96 General Requirements (Recodified)
140.97 Special Requirements (Recodified)
140.98 Covered Hospital Services (Recodified)
140.99 Hospital Services Not Covered (Recodified)
140.100 Limitation On Hospital Services (Recodified)
140.101 Transplants (Recodified)
140.102 Heart Transplants (Recodified)
140.103 Liver Transplants (Recodified)
140.104 Bone Marrow Transplants (Recodified)
140.110 Disproportionate Share Hospital Adjustments (Recodified)
140.116 Payment for Inpatient Services for GA (Recodified)
140.117 Hospital Outpatient and Clinic Services (Recodified)
140.200 Payment for Hospital Services During Fiscal Year 1982 (Recodified)
140.201 Payment for Hospital Services After June 30, 1982 (Repealed)
140.202 Payment for Hospital Services During Fiscal Year 1983 (Recodified)
140.203 Limits on Length of Stay by Diagnosis (Recodified)

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140.300 Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Recodified)
140.350 Copayments (Recodified)
140.360 Payment Methodology (Recodified)
140.361 Non-Participating Hospitals (Recodified)
140.362 Pre July 1, 1989 Services (Recodified)
140.363 Post June 30, 1989 Services (Recodified)
140.364 Prepayment Review (Recodified)
140.365 Base Year Costs (Recodified)
140.366 Restructuring Adjustment (Recodified)
140.367 Inflation Adjustment (Recodified)
140.368 Volume Adjustment (Repealed)
140.369 Groupings (Recodified)
140.370 Rate Calculation (Recodified)
140.371 Payment (Recodified)
140.372 Review Procedure (Recodified)
140.373 Utilization (Repealed)
140.374 Alternatives (Recodified)
140.375 Exemptions (Recodified)
140.376 Utilization, Case-Mix and Discretionary Funds (Repealed)
140.390 Subacute Alcoholism and Substance Abuse Services (Recodified)
140.391 Definitions (Recodified)
140.392 Types of Subacute Alcoholism and Substance Abuse Services (Recodified)
140.394 Payment for Subacute Alcoholism and Substance Abuse Services (Recodified)
140.396 Rate Appeals for Subacute Alcoholism and Substance Abuse Services (Recodified)
140.398 Hearings (Recodified)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section
140.400 Payment to Practitioners, Nurses and Laboratories
140.410 Physicians' Services
140.411 Covered Services By Physicians
140.412 Services Not Covered By Physicians
140.413 Limitation on Physician Services
140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items - Physicians
140.416 Optometric Services and Materials
140.417 Limitations on Optometric Services
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140.422 Requirements for Prescriptions and Dispensing Items of Pharmacy Items - Dentists
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140.426 Limitations on Podiatry Services
140.427 Requirement for Prescriptions and Dispensing of Pharmacy Items - Podiatry
140.428 Chiropractic Services
140.429 Limitations on Chiropractic Services (Repealed)
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140.431 Services Not Covered by Independent Laboratory
140.432 Limitations on Independent Laboratory Services
140.433 Payment for Laboratory Services
140.434 Record Requirements for Independent Laboratories
140.435 Nurse Services
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140.440 Pharmacy Services
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140.442 Prior Approval of Prescriptions
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140.446 Over-the-Counter Items
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140.448 Returned Pharmacy Items
140.449 Payment of Pharmacy Items
140.450 Record Requirements for Pharmacies
140.452 Mental Health Clinic Services
140.453 Definitions
140.454 Types of Mental Health Clinic Services
140.455 Payment for Mental Health Clinic Services
140.456 Hearings
140.457 Therapy Services
140.458 Prior Approval for Therapy Services
140.459 Payment for Therapy Services
140.460 Clinic Services
140.461 Clinic Participation, Data and Certification
140.462 Covered Services in Clinics
140.463 Clinic Service Payment
140.464 Healthy Moms/Healthy Kids Managed Care Clinics
140.465 Speech and Hearing Clinics (Repealed)
140.466 Rural Health Clinics
140.467 Independent Clinics
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140.471 Home Health Covered Services
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140.477 Limitations on Equipment, Supplies and Prosthetic Devices
140.478 Prior Approval for Medical Equipment, Supplies and Prosthetic Devices
140.479 Limitations, Medical Supplies
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140.481 Payment for Medical Equipment, Supplies and Prosthetic Devices
140.482 Family Planning Services
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140.485 Healthy Kids Program
140.486 Limitations on Medichek Services (Repealed)
140.487 Healthy Kids Program Timeliness Standards
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SUBPART E: GROUP CARE

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140.500 Group Care Services
140.502 Cessation of Payment at Federal Direction
140.503 Cessation of Payment for Improper Level of Care
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140.505 Continuation of Payment Because of Threat To Life
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140.510 Determination of Need for Group Care
140.511 Long Term Care Services Covered by Department Payment
140.512 Utilization Control
140.513 Utilization Review Plan (Repealed)
140.514 Certifications and Recertifications of Care
140.515 Management of Recipient Funds--Personal Allowance Funds
140.516 Recipient Management of Funds
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140.519 Use or Accumulation of Funds
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140.524 Cessation of Payment Due to Loss of License
140.525 Quality Incentive Program (QUIP) Payment Levels
140.526 Quality Incentive Standards and Criteria for the Quality Incentive Program (QUIP) (Repealed)

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140.527 Quality Incentive Survey (Repealed)
140.528 Payment of Quality Incentive (Repealed)
140.529 Reviews (Repealed)
140.530 Basis of Payment for Long Term Care Services
140.531 General Service Costs
140.532 Health Care Costs
140.533 General Administration Costs
140.534 Ownership Costs
140.535 Costs for Interest, Taxes and Rent
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140.540 Costs Associated With Nursing Home Care Reform Act and Implementing Regulations
140.541 Salaries Paid to Owners or Related Parties
140.542 Cost Reports-Filing Requirements
140.543 Time Standards for Filing Cost Reports
140.544 Access to Cost Reports (Repealed)
140.545 Penalty for Failure to File Cost Reports
140.550 Update of Operating Costs
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140.552 Nursing and Program Costs
140.553 General Administrative Costs
140.554 Component Inflation Index
140.555 Minimum Wage
140.560 Components of the Base Rate Determination
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140.565 Kosher Kitchen Reimbursement
140.566 Out-of-State Placement
140.567 Level II Incentive Payments (Repealed)
140.568 Duration of Incentive Payments (Repealed)
140.569 Clients With Exceptional Care Needs
140.570 Capital Rate Component Determination
140.571 Capital Rate Calculation
140.572 Total Capital Rate
140.573 Other Capital Provisions
140.574 Capital Rates for Rented Facilities
140.575 Newly Constructed Facilities (Repealed)
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140.580 Mandated Capital Improvements (Repealed)
140.581 Qualifying as Mandated Capital Improvement (Repealed)
140.582 Cost Adjustments

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140.583 Campus Facilities
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140.647 Description of Developmental Training (DT) Services
140.648 Determination of the Amount of Reimbursement for Developmental Training (DT) Programs
140.649 Effective Dates of Reimbursement for Developmental Training (DT) Programs
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140.652 Terms of Assurances and Contracts
140.680 Effective Date Of Payment Rate
140.700 Discharge of Long Term Care Residents
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SUBPART F: MEDICAID PARTNERSHIP PROGRAM

Section
140.850 General Description (Repealed)
140.855 Definition of Terms (Repealed)
140.860 Covered Services (Repealed)
140.865 Sponsor Qualifications (Repealed)
140.870 Sponsor Responsibilities (Repealed)
140.875 Department Responsibilities (Repealed)
140.880 Provider Qualifications (Repealed)
140.885 Provider Responsibilities (Repealed)
140.890 Payment Methodology (Repealed)
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SUBPART G: HEALTHY MOMS/HEALTHY KIDS PROGRAM

Section
140.900 Reimbursement For Nursing Costs For Geriatric Residents in Group Care Facilities (Recodified)
140.901 Functional Areas of Needs (Recodified)
140.902 Service Needs (Recodified)

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140.903 Definitions (Recodified)
140.904 Times and Staff Levels (Repealed)
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140.924 Provider Participation Requirements
140.926 Client Eligibility
140.928 Client Enrollment and Program Components
140.930 Reimbursement
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SUBPART H: ILLINOIS COMPETITIVE ACCESS AND REIMBURSEMENT EQUITY (ICARE) PROGRAM

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140.942 Definition of Terms (Recodified)
140.944 Notification of Negotiations (Recodified)
140.946 Hospital Participation in ICARE Program Negotiations (Recodified)
140.948 Negotiation Procedures (Recodified)
140.950 Factors Considered in Awarding ICARE Contracts (Recodified)
140.952 Closing an ICARE Area (Recodified)
140.954 Administrative Review (Recodified)
140.956 Payments to Contracting Hospitals (Recodified)
140.958 Admitting and Clinical Privileges (Recodified)
140.960 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Recodified)
140.962 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Recodified)
140.964 Contract Monitoring (Recodified)
140.966 Transfer of Recipients (Recodified)
140.968 Validity of Contracts (Recodified)
140.970 Termination of ICARE Contracts (Recodified)
140.972 Hospital Services Procurement Advisory Board (Recodified)
140.980 Elimination Of Aid To The Medically Indigent (AMI) Program
140.982 Elimination Of Hospital Services For Persons Age Eighteen (18) And Older And Persons Married And Living With Spouse, Regardless Of Age

TABLE A Medichek Recommended Screening Procedures (Repealed)
TABLE B Health Service Areas

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TABLE C	Capital Cost Areas
TABLE D	Schedule of Dental Procedures
TABLE E	Time Limits for Processing of Prior Approval Requests
TABLE F	Podiatry Service Schedule
TABLE G	Travel Distance Standards
TABLE H	Areas of Major Life Activity
TABLE I	Staff Time and Allocation for Training Programs (Recodified)
TABLE J	HSA Grouping (Repealed)
TABLE K	Services Qualifying for 10% Add-On (Repealed)
TABLE L	Services Qualifying for 10% Add-On to Surgical Incentive Add-On (Repealed)
TABLE M	Enhanced Rates for Healthy Moms/Healthy Kids Provider Services

AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1993, ch. 111 1/2, par. 6503-1 et seq.) [20 ILCS 2215/Art. III] and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13) [305 ILCS 5/Arts. III, IV, V, VI and VII and 12-13].

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24,

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1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg.7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246,

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effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1998, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a

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maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; Section 140.569 withdrawn at 15 Ill. Reg. 1174; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; emergency amendment at 17 Ill. Reg. 11201,

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effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; emergency amendment suspended effective October 12, 1993; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2932, effective March 1, 1995; emergency amendment at 19 Ill. Reg. _____, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. _____, effective _____.

SUBPART C: PROVIDER ASSESSMENTS

Section 140.80 Hospital Provider Fund

a) Purpose and Contents
   1) The Hospital Provider Fund ("Fund") was created in the State Treasury upon enactment of Public Act 87-861 and Public Act 88-88. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.
   2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-861, as amended by Public Act 88-88.
   3) The Fund shall consist of:
      A) All monies collected or received by the Department under subsection (b) below;
      B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;
      C) Any interest or penalty levied in conjunction with the administration of the Fund;
      D) All other monies received for the Fund from any other source, including interest earned thereon;
      E) All monies transferred from the Hospital Services Trust Fund; and
      F) All monies transferred from the Tobacco Products Tax Act.

b) Provider Assessments
   Beginning on July 1, 1993, and ending on June 30, 1994, an assessment is imposed upon each hospital provider in an amount equal to 1.88% of the provider's adjusted gross hospital revenue, as described in subsection (1)(1) of this Section, for the most recent calendar year ending before the beginning of that State fiscal year. An assessment is imposed upon each hospital provider for the fiscal year beginning on July 1, 1994, and ending on June 30, 1995, in an amount equal to the provider's adjusted gross hospital revenue, as described in subsection (1)(1) of this Section, for the most recent calendar year ending before the beginning of that State fiscal year multiplied by the Provider's Savings Rate, as described in subsection (1)(10) of this Section. The Department reserves the right to audit the reported data. The Department shall notify hospital providers of the Provider's Savings Rate by mailing a notice to each provider's last known address as reflected by the records of the Department.

c) Payment of Assessment Due
   1) The assessments imposed in subsection (b) above shall be due and payable in quarterly installments, each equalling one-fourth of the assessment for the year, on September 30, December 31, March 31, and May 31 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the quarterly due dates. Assessment payments postmarked on the due date will be considered as paid on time.
   2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

d) Reporting Requirements, Penalty, and Maintenance of Records
   1) After December 31 of each year, and on or before March 31 of the succeeding year, every hospital provider subject to an assessment under subsection (b) above shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross hospital revenue from the calendar year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the next July 1. If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, a separate report shall be filed for each hospital. In the case of a hospital provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.
   2) If the hospital provider fails to file its report for a State fiscal year on or before the due date of the report, there shall be, unless waived by the Department for reasonable cause, added to the assessment imposed in subsection (b) above a penalty assessment equal to 25% of the assessment imposed for the year.
   3) Every hospital provider subject to an assessment under subsection (b) above shall keep records and books that will permit the determination of adjusted gross hospital revenue on a calendar

year basis. All such books and records shall be maintained for a minimum of three years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsections (d)(5) or (6) below, an amended assessment report must be filed within 30 calendar days of the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

5) Submission of Financial Audit Statements. All hospital providers are required to submit a copy of all financial statements audited by an external, independent auditor, to the Department within 30 days after the close of such externally performed financial audits. If the hospital's year end does not coincide with the December 31 ending date for the assessment report, the hospital must submit all financial audits covering the assessment report period. An amended assessment report must accompany such external financial audit statements if the data submitted on the initial assessment report changes based upon the findings of such external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.

6) Reconsideration of Adjusted Assessment. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a hospital provider, the hospital provider may request a review or reconsideration of the adjusted assessment within 30 days after the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. If a hospital provider ceases to conduct, operate, or maintain a hospital for which the person is subject to assessment under subsection (b) above, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) by a fraction, the numerator of which is the number of days

in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. The person shall file a final, amended report with the Department not more than 30 calendar days after the cessation, reflecting the adjustment, and shall pay with the final return the assessment for the year as so adjusted, to the extent not previously paid.

2) Commencing of business during the fiscal year in which the assessment is being paid. A hospital provider who commences conducting, operating, or maintaining a hospital for which the person is subject to assessment under subsection (b) above, shall file an initial report for the State fiscal year in which the commencement occurs within 30 calendar days thereafter and shall pay the assessment under subsection (d) above as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.

3) Partial Calendar Year Operation Adjustment. For a hospital provider that did not conduct, operate, or maintain a hospital throughout the entire calendar year reporting period, the assessment for the following State fiscal year shall be annualized based on the provider's actual revenues for the portion of the reporting period the hospital was operational (dividing adjusted gross hospital revenue by the number of days the hospital was in operation and then multiplying the amount by 365). Revenues realized by a prior provider from the same hospital during the calendar year shall be used in the annualization equation, if available.

4) Change in Ownership and/or Operations. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rest on the hospital provider currently operating or maintaining the hospital regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liability incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any hospital that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for

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reasonable cause, a penalty equal to 5% of the amount of the installment not paid on or before the due date, plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100% of the installment amount not paid on or before the due date.

2) Within 45 days from the due date, the Department may begin recovery actions against delinquent hospitals participating in the Medicaid Program. Payments may be withheld from the hospital until the entire assessment, including any penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached or if a hospital fails to comply with an agreement, the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the hospital's future payments from the Department. The provider may appeal this recoupment in accordance with Department rules contained in 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) above will continue to accrue during the recoupment process. Recoupment proceedings against the same hospital two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 45 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the hospital does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months after the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Hospitals
The Director may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

1) the State delays payments to hospitals due to problems related to State cash flow, or

2) a cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a significant number of hospitals will be unable to obtain a loan to pay the assessment.

h) Delayed Payment - Individual Hospitals
In addition to the provisions of subsection (g) above, the Director may delay assessments for individual hospitals that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment

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was to have been received by the Department as described in subsection (c) above.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions may be made only to qualified hospitals who meet all of the following requirements:

A) the provider has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1) and (f)(2) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a provider which are unrelated to Department technical system problems and which result in extensive financial problems to a facility, adversely impacting on its ability to serve its clients.

B) the provider serves a significant number of clients under the medical assistance program. "Significant" in this instance means:

i) a hospital that serves a significant number of clients under the medical assistance program; significant in this instance means that the hospital qualifies as a disproportionate share hospital under 89 Ill. Adm. Code 148.120(a)(1) through 148.120(a)(5); or qualifies as a Medicare DSH hospital under the current federal guidelines.

ii) a government-owned facility, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.

iii) a hospital which has filed for Chapter 11 bankruptcy, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.

C) the provider must file a delay of payment request as defined under subsection (h)(3)(A) below, and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0.

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.

D) the provider must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institution such as a commercial bank. The denial must be 90 days old or less.

E) the provider must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver as described in subsection (h)(5) that shall be due from the provider as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement; ~~and~~

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signature's knowledge~~.~~; and

vi) such other terms and conditions that may be required by the Department.

2) A hospital which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, providers must submit their request in writing

(telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received ~~as follows:--delayed--payment--requests-for-installments-due-on September-30-of-the-year--must--be--received--on--or--before September--10--of--the--year;--delayed--payment-requests-for installments-due-on-December-31-of-the-year-must-be-received on-or-before--December--10--of--the--year;--delayed--payment requests--for--installments-due-on-March-31-of-the-year-must be-received-on-or-before-March-11-of-the-year;--and--delayed payment--requests-for-installments-due-on-May-31-of-the-year must-be-received-on-or-before-May-10-of-the-year~~ by the date designated by the Department. Providers will be notified, in writing, as to the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) of this Section, a denial of application to borrow the assessment as defined in subsection (h)(1)(D) of this Section and an explanation of the risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the provider.

B) The hospital shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the provider's request for institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the provider fails to meet all of the terms and conditions of the agreement. In the event the provider

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fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above, is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B) above. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delayed payment agreement. The waiver of penalties described in subsection (h)(4) shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions

Pursuant to Section 5A-7 of P.A. 86-861, to the extent practicable, the Department shall administer and enforce P.A. 86-861, as amended by P.A. 88-88, and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Exemptions

1) A rural hospital, as defined in subsection (l)(11) below, shall be exempt from the assessment imposed under subsection (b), unless the exemption is a judged to be unconstitutional or otherwise invalid, in which case the provider shall pay the assessment imposed under subsection (b) above.

2) A hospital provider which is a county with a population of more than 3,000,000 that makes intergovernmental transfer payments as provided in Section 15-3 of P.A. 87-861, as amended by P.A. 88-85 and P.A. 88-88, shall be exempt from the assessment imposed by subsection (b) above, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital shall pay the assessment imposed by subsection (b) above for all assessment periods beginning on or after July 1, 1992, and the assessment so paid shall be creditable against the intergovernmental transfer payments.

3) The Department is authorized to enter into an interagency

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agreement with a hospital organized under the University of Illinois Hospital Act exempt from the assessment imposed under subsection (b) of this Section, to make intergovernmental transfer payments to the Department. Effective July 1, 1994, ~~These~~ these payments shall be deposited into the ~~General--Revenue Fund~~ University of Illinois Fund, as mandated under Public Act 88-554.

4) The Department is also authorized to enter into agreements with publicly owned or operated hospitals not described in subsections (j)(1) through (j)(3) above to make intergovernmental transfer payments to the Department. These payments shall be deposited into the Hospital Provider Fund.

5) Facilities operated by the Department of Mental Health and Developmental Disabilities which are accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO), shall be exempt from the assessment imposed by subsection (b) above.

k) Nothing in P.A. 88-88 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before the effective date of P.A. 88-88.

l) Definitions

As used in this Section, unless the context requires otherwise:

1) "Adjusted gross hospital revenue" means the hospital provider's total gross patient charges less Medicare contractual allowances, but does not include gross patient revenue (and the portion of any Medicare contractual allowance related thereto) from skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act. Revenue generated from swing beds, as described in subsection (l)(12) below, is considered to be part of the provider's gross hospital revenue. Revenue not related to patient care, such as investment income, gift shop, cafeteria, or parking lot revenue, is not considered as patient revenue. Adjusted gross hospital revenue must be reported on an accrual basis for the assessment reporting period. All patient revenue accrued during the assessment reporting period must be included even though reimbursement may occur after the assessment reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the hospital's last two cost reports.

2) "Cigarette Tax Contribution" is the sum of the total amount deposited in the Hospital Provider Fund in State fiscal year 1994 pursuant to Section 2(a) of the Cigarette Tax Act, plus the total amount deposited in the Hospital Provider Fund in State fiscal year 1994 pursuant to Section 5A-3(c) of Public Act 88-88.

3) "Department" means the Illinois Department of Public Aid.

4) "Fund" means the Hospital Provider Fund.

5) "Hospital" means an institution, place, building, or agency located in this State that is subject to licensure by the

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Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located.

6) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

7) "Intergovernmental transfer payment/Interagency Agreement" means the payments established under Section 15-3 of P.A. 87-861, as amended by P.A. 88-85, ~~and~~ P.A. 88-88 and P.A. 88-554, and includes without limitation payments payable under that Section for July, August and September of 1992.

8) "Maximum Section 5A-2 Contribution" is the total amount of tax imposed by Section 5A-2 of Public Act 88-88 in State fiscal year 1994 on providers subject to the assessment imposed by subsection (b) above; multiplied by a fraction the numerator of which is adjusted gross hospital revenues reported to the Department by providers subject to the assessment imposed by subsection (b) for State fiscal year 1994 and the denominator of which is adjusted gross hospital revenues reported to the Department by providers subject to the assessment imposed by subsection (b) for State fiscal year 1993.

9) "Medicare Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by Medicare, as appropriate, pursuant to agreements between the hospital and the Health Care Financing Administration.

10) "Provider's Savings Rate" is 1.88% multiplied by a fraction, the numerator of which is the Maximum Section 5A-2 Contribution minus the Cigarette Tax Contribution, and the denominator of which is the Maximum Section 5A-2 Contribution.

11) "Rural hospital" means a hospital that is either located outside a metropolitan statistical area, or is located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health. The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993). Appeals of the geographic designation of

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hospital provider shall be in accordance with 89 Ill. Adm. Code 148.310(m).

12) "Swing-beds" means those beds for which a hospital provider has been granted an approval from the federal Health Care Financing Administration to provide post-hospital extended care services (42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 140.82 Developmentally Disabled Care Provider Fund

a) Purpose and Contents

1) The Developmentally Disabled Care Provider Fund was created in the State Treasury upon enactment of Public Act 87-861 and Public Act 88-88. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-861, as amended by Public Act 88-88.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) below;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) All other monies received for the Fund from any other source, including interest earned thereon; and

E) All monies transferred from the Medicaid Developmentally Disabled Provider Participation Fee Trust Fund.

b) Provider Assessments

Beginning on July 1, 1993, an assessment is imposed upon each developmentally disabled care provider for the State fiscal year beginning on July 1, 1993, and ending on June 30, 1995, in an amount equal to six percent of its adjusted gross developmentally disabled care revenue for the prior State fiscal year. Adjusted gross developmentally disabled care revenue for the fiscal year beginning on July 1, 1993, will be based upon the provider's annualized State fiscal year 1993 revenue. Adjusted gross developmentally disabled care revenue for the fiscal year beginning on July 1, 1994, will be based upon the provider's annualized State fiscal year 1994 revenue. The revenue for each year will be reported on the Developmentally Disabled Care Provider Tax form to be filed by a date designated by the Department. The Department reserves the right to audit the reported

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c) Payment of Assessment Due

1) The assessment described in subsection (b) above shall be due and payable in quarterly installments, each equalling one-fourth of the assessment for the year, on September 30, December 31, March 31, and May 31 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the due dates. Assessment payments postmarked on the due date will be considered paid on time.

2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) After June 30 of each State fiscal year, and on or before September 30 of the succeeding State fiscal year, every developmentally disabled care provider subject to an assessment under subsection (b) above shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross developmentally disabled care revenue from the State fiscal year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the preceding July 1. If a developmentally disabled care provider operates or maintains more than one developmentally disabled care facility, a separate report shall be filed for each facility. In the case of a developmentally disabled care provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

2) If the developmentally disabled care provider fails to file its report for a State fiscal year on or before the due date of the report, there shall be, unless waived by the Department for reasonable cause, added to the assessment imposed in subsection (b) above a penalty assessment equal to 25% of the assessment imposed for the year.

3) Every developmentally disabled care provider subject to an assessment under subsection (b) above shall keep records and books that will permit the determination of adjusted gross developmentally disabled care revenue on a State fiscal year basis. All such books and records shall be maintained for a minimum of three years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsection (d)(5) or (6) below, an amended assessment report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

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5) Submission of Financial Audit Statements. All developmentally disabled care providers are required to submit a copy of all financial statements audited by an external, independent auditor to the Department within 30 days of the close of such externally performed financial audits. If the provider's year end does not coincide with the June 30th ending date for the assessment report, the provider must submit all financial audits covering the assessment report period. An amended assessment report must accompany such external financial audit statements if the data submitted on the initial assessment report changes based upon the findings of such external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.

6) Reconsideration of Adjusted Assessment. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a developmentally disabled care provider, the developmentally disabled care provider may request a review or reconsideration of the adjusted assessment within 30 days of the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. For a developmentally disabled care provider who ceases to conduct, operate, or maintain a facility to which the person is subject to assessment under subsection (b) above, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the facility and the denominator of which is 365. The person shall file a final, amended report with the Department not more than 30 calendar days after the cessation, reflecting the adjustment, and shall pay with the final report the assessment for the year as so adjusted, to the extent not previously paid.

2) Commencing of business during the fiscal year in which the

assessment is being paid. A developmentally disabled care provider who commences conducting, operating, or maintaining a facility of which the person is subject to assessment under subsection (b) above, shall file an initial return for the State fiscal year in which the commencement occurs within 30 calendar days thereafter and shall pay the assessment under subsection (d) above as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.

3) Partial Fiscal Year Operation Adjustment. For a developmentally disabled care provider that did not conduct, operate, or maintain a facility throughout the entire fiscal year reporting period, the assessment for the following State fiscal year shall be annualized based on the provider's actual developmentally disabled care revenue for the portion of the reporting period the facility was operational (dividing adjusted developmentally disabled care revenue by the number of days the facility was in operation and then multiplying that amount by 365). Developmentally disabled care revenue realized by a prior provider from the same facility during the fiscal year shall be used in the annualization equation, if available.

4) Changes in Ownership and/or Operators. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount rests on the developmentally disabled care provider currently operating or maintaining the developmentally disabled care facility regardless if these amount were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any facility that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to 5% of the amount of the installment not paid on or before the due date, plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100% of the installment amount not paid

on or before the due date.

2) Within45 days from the due date, the Department may begin recovery actions against delinquent facilities participating in the Medicaid Program. Payments may be withheld from the facility until the entire assessment, including any penalties, is satisfied, or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if the facility fails to comply with an agreement the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with Department rules contained in 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) above will continue to accrue during the recoupment process. Recoupment proceedings against the same facility two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 45 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the facility does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months of the assessment due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Facilities

The Director may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of facilities when:

1) the State delays payments to facilities due to problems related to State cash flow, or

2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the assessment.

h) Delayed Payment - Individual Facilities

In addition to the provisions of subsection (g) above, the Director may delay assessments for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) above.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provision shall be made only to qualified facilities who meet all of the

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following requirements:

A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:
   i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;
   ii) cash flow problems encountered by a facility which are unrelated to Department technical system problems and which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.

B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:
   i) 85 percent or more of their residents must be eligible for public assistance.
   ii) a government-owned facility, which meets the cash flow criteria under subsection (h)(1)(A)(ii) above.
   iii) a provider who has filed for Chapter 11 bankruptcy, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.

C) the facility must file a delay of payment request as defined in subsection (h)(3)(A) below, and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:
   i) the ratio of current assets divided by current liabilities is greater than 2.0;
   ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;
   iii) cash or other assets have been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institution such as a commercial bank. The denial must be 90 days old or less.

E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:
   i) specific reason(s) for institution of the delayed payment provisions;
   ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;
   iii) the interest or a statement of interest waiver as described in subsection (h)(5) that shall be due from the facility as a result of institution of the delayed payment provisions;
   iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;
   v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signature's knowledge; and
   vi) such other terms and conditions that may be required by the Department.

2) A facility which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process
   A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received as

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~~follows:--delayed--payment--requests-for-installments-due-on September-30-of-the-year--must--be--received--on--or--before September--1?--of-the-year;-and-delayed-payment-requests-for installments-due-on-December-31-of-the-year-must-be-received on-or-before--December--10--of--the--year;--delayed--payment requests--for--installments-due-on-March-31-of-the-year-must be-received-on-or-before--March--11--of--the--year;--delayed payment--requests-for-installments-due-on-May-31-of-the-year must-be-received-on-or-before-May-10-of-the-year~~ by the due date designated by the Department. Providers will be notified, in writing, of the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be

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waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above, is 1.5 or less and the facility meets the criteria in (h)(1)(A) and (B). Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration; enforcement provisions
Pursuant to Section 5C-6 of P.A. 86-861, to the extent practicable, the Department shall administer and enforce P.A. 86-861, as amended by P.A. 88-88, and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Nothing in P.A. 88-88 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment impose before the effective date of P.A. 88-88.

k) Definitions

1) "Adjusted gross developmentally disabled care revenue" means the developmentally disabled care provider's total revenue for inpatient residential services, less contractual allowances and discounts on patients' accounts, but does not include non-patient revenue from sources such as contributions, donations or bequests, investments, day training services, television and telephone service, rental of facility space, or sheltered care revenue. Adjusted gross developmentally disabled care revenue must be reported on an accrual basis for the tax reporting period. All patient revenue accrued during the tax reporting period must be included even though reimbursement may occur after the tax reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the facility's last two cost reports.

2) "Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by third party payors or patients, as appropriate, pursuant to agreements/contracts with the developmentally disabled care provider; courtesy and policy discounts provided to employees, medical staff and clergy; and charity care, but "contractual

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allowance" does not mean any Provider Participation fees/taxes paid to the Illinois Department of Public Aid.

3) "Department" means the Illinois Department of Public Aid.

4) "Developmentally disabled care facility" means an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.

5) "Developmentally disabled care provider" means a person conducting, operating, or maintaining a developmentally disabled care facility. For this purpose, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian or other representative appointed by order of any court.

6) "Facility" means all intermediate care facilities as defined under "Developmentally disabled care facility" above.

7) "Fund" means the Developmentally Disabled Care Provider Fund.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 140.84 Long Term Care Provider Fund

a) Purpose and Contents

1) The Long Term Care Provider Fund was created in the State Treasury upon enactment of Public Act 87-861 and Public Act 88-88. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-861, as amended by Public Act 88-88.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) below;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) All other monies received for the Fund from any other source, including interest earned thereon;

E) All monies transferred from the Medicaid Long Term Care Provider Participation Fee Trust Fund; and

F) All monies transferred from the Tobacco Products Tax Act.

b) License Fee

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Beginning on July 1, 1993, a nursing home license fee is imposed upon each nursing home provider for the State fiscal year beginning on July 1, 1993, and ending on June 30, 1995, in an amount equal to $1.50 for each licensed bed day for the calendar quarter in which the payment is due. All nursing home beds subject to licensure under the Nursing Home Care Act or the Hospital Licensing Act, with the exception of swing-beds, as defined in subsection (k)(8) of this Section will be used to calculate the licensed bed days for each quarter. This license fee shall not be billed or passed on to any resident of a nursing home operated by the nursing home providers. Changes in the number of licensed beds will be reported to the Department quarterly, as described in subsection (d)(1) below. The Department reserves the right to audit the reported data.

c) Payment of License Fee Due

1) The license fee described in subsection (b) above shall be due and payable in quarterly installments, on September 10, December 10, March 10, and June 10 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the quarterly due dates. License fee payments postmarked on the due date will be considered as paid on time.

2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

3) County nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their license fee obligation by the county government certifying to the Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the license fee. County governments wishing to provide such certification must:

A) Sign a certification form certifying that the funds represent expenditures eligible for federal financial participation under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and that these funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds;

B) Submit the certification document to the Department once a year along with a copy of that portion of the county budget showing the funds appropriated for the operation of the county nursing home. These documents must be submitted within 30 days after the final approval of the county budget. The county budget and/or budgets covering the State fiscal year of July 1, 1993, through June 30, 1995, must be submitted by a date designated by the Department;

C) Submit the monthly claim form in the amount of the rate established by the Department minus any third party liability amount. This amount will be reduced by an amount determined by the amount certified and the number of months

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remaining in the fiscal year, prior to payment because a certification statement was provided in lieu of an actual license fee payment; and

D) Make records available upon request to the Department and/or the United States Department of Health and Human Services pertaining to the certification of county funds.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) On or before the due dates described in subsection (c)(1), each nursing home provider subject to a license fee under subsection (b) of this Section shall file a report with the Department reflecting any changes in the number of licensed beds occurring during the reporting quarter. The report shall be on a form prepared by the Department. The changes will be reported quarterly and shall be submitted with the revised quarterly license fee payment. For the purpose of calculating the license fee described in subsection (b) above, all changes in licensed beds will be effective upon approval of the change by the Illinois Department of Public Health. Documentation showing the change in licensed beds, and the date the change was approved by the Illinois Department of Public Health, must be submitted to the Department of Public Aid with the licensed bed change form. If a nursing home provider operates or maintains more than one nursing home, a separate report shall be filed for each facility. In the case of a nursing home provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

2) If the nursing home provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the license fee imposed in subsection (b) above a penalty fee equal to 25% of the license fee imposed for the year.

3) Every nursing home provider subject to a license fee under subsection (b) above shall keep records and books that will permit the determination of bed days on a quarterly basis. All such books and records shall be maintained for a minimum of three years following the filing date of the license fee report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended License Fee Reports. With the exception of amended license fee reports filed in accordance with subsection (d)(5) below, an amended license fee report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual license fee amount through a written notification from the Department.

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Penalties may be applied to the amount underpaid due to a filing error.

5) Reconsideration of Adjusted License Fee. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment/license fee was due, changes the license fee liability of a nursing home provider, the nursing home provider may request a review or reconsideration of the adjusted license fee within 30 days of the Department's notification of the change in license fee liability. Requests for reconsideration of the license fee adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the quarter in which the license fee is being paid and the closure date has been set. A nursing home provider who ceases to conduct, operate, or maintain a facility to which the person is subject to the license fee imposed under subsection (b) above, and for which the closure date for the facility has been set, shall file a final report with the Department on or before the due date for the quarter in which the closure is to occur. The report will reflect the adjusted number of days the facility is open during the reporting quarter, and shall be submitted with the final quarterly payment Example: A facility is set to close on September 24. On or before the due date ~~of September 10~~, for the reporting quarter of July 1 through September 30, the facility will submit a final report reflecting 86 days of the operation (July 1 through September 24) and the corresponding quarterly license fee payment.

2) Cessation of business after the quarterly due date. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) above, and for which closure occurs after the due date for the reporting quarter, but prior to the last day of the reporting quarter, shall file an amended final report with the Department within 30 days after the closure date. The amended report will reflect the number of days the facility was operated during the reporting quarter and the revised license fee amount. Upon verifying the data submitted on the amended report, the Department will issue a refund for the amount overpaid. Example: On December 10 a facility pays the license fee for 92 days covering the reporting quarter of October 1 through December 31. The facility closes December 27. An amended report reflecting 88 days, the actual number of days the facility was operational during the quarter (October 1 through December 27) must be filed with the Department.

3) Cessation of business prior to the quarterly due date. A nursing

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home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) above, and for which closure occurs prior to the due date for the reporting quarter, shall file a final report with the Department within 30 days after the closure date. The final report will reflect the number of days the facility was operational during the reporting during the quarter and the corresponding final license fee amount. Closure dates will be verified with the Department of Public Health, and if necessary adjustments will be made to the final license fee due. Example: Facility closes on January 17. On or before February 17, the facility must file a final report for the reporting quarter of January 1 through March 31. The report would reflect 17 days of operation (January 1 through January 17) during the quarter and must be accompanied by the final license fee payment for the facility.

4) Commencing of business during the fiscal year in which the license fee is being paid. A nursing home provider who commences conducting, operating, or maintaining a facility for which the person is subject to the license fee imposed under subsection (b) above, shall file an initial report for the reporting quarter in which the commencement occurs within 30 calendar days thereafter and shall pay the license fee under subsection (d) above.

5) Change in ownership and/or operators. The full quarterly assessment license fee must be paid on the designated due date regardless of changes in ownership operators. Liability for the payment of the assessment/license fee amount (including past due assessment/license fees and any interest or penalties that may have accrued against the amount) rests on the nursing home provider currently operating or maintaining the nursing facility regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment/license fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment/license fee liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any nursing home provider that fails to pay the full amount of an installment when due, or fails to report a change in licensed beds approved by the Department of Public Health prior to the due date of installment, shall be charged, unless waived by the Department for reasonable cause, a penalty equal to 5% of the amount of the installment not paid on or before the due date, plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100% of the installment amount not paid on or before the due date.

2) Within 45 days from the due date, the Department may begin

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recovery actions against delinquent nursing home providers participating in the Medicaid Program. Payments may be withheld from the provider until the entire license fee, including any penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if a provider fails to comply with an agreement, the Department reserves the right to recover any outstanding license fee, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with the Department rules contained in 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) above will continue to accrue during the recoupment process. Recoupment proceedings against the same nursing home provider two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 45 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the nursing home provider does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months after the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Facilities

The Director may establish delayed payment of fees and/or waive the payment of interest and penalties for groups of facilities when:

1) the State delays payments to facilities due to problems related to State cash flow, or

2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the license fee.

h) Delayed Payment - Individual Facilities

In addition to the provisions of subsection (g) above, the Director may delay license fees for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the license fee was to have been received by the Department as described in subsection (c) above.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:

A) the facility has experienced an emergency which necessitates

institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a facility which are unrelated to Department technical system problems and which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.

B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) 85 percent or more of their residents must be eligible for public assistance.

ii) a government-owned facility, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.

iii) a provider who has filed for Chapter 11 bankruptcy, which meets cash flow criterion under subsection (h)(1)(A)(ii).

C) the facility must file a delay of payment request as defined under subsection (h)(3)(A) and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of license fee payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0;

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the license fee payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;

iii) cash or other assets have been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the license fee payment for dividends, salaries in excess of those allowable

under Section 140.541 or payment for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow license fee funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver as described in subsection (h)(5) below that shall be due from the facility as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signature's knowledge; and

vi) such other terms and conditions that may be required by the Department.

2) A facility which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received ~~as follows:--delayed-payment-requests-for-installments--due--on September--10--of--the--year--must--be-received-on-or-before~~

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~~August 20 of the year; delayed payment requests for installments due on December 10 of the year must be received on or before November 22 of the year; delayed payment requests for installments due on March 10 of the year must be received on or before February 10 of the year; and delayed payment requests for installments due on June 10 of the year must be received on or before May 20 of the year~~ by the due date designated by the Department. Providers will be notified, in writing, of the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests ~~by certified mail~~, postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) a denial of application to borrow the license fee as defined in subsection (h)(1)(D) and an explanation risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing prior to the license fee due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above, is 1.5 or less and the facility meets the criteria in (h)(1)(A) and (B). Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration; enforcement provisions
Pursuant to Section 5B-7 of P.A. 87-861, to the extent practicable, the Department shall administer and enforce P.A. 86-861, as amended by P.A. 88-88, and collect the license fees, interest, and penalty fees imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Nothing in P.A. 88-88 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before the effective date of P.A. 88-88.

k) Definitions
As used in this Section, unless the context requires otherwise:

1) "Department" means the Illinois Department of Public Aid.

2) "Fund" means the Long-Term Care Provider Fund.

3) "Hospital Provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

4) "Licensed bed days" means, with respect to a nursing home provider, the sum for all nursing home beds, with the exception of swing-beds, as described in subsection (k)(8) of this Section, of the number of days during a calendar quarter on which each bed is covered by a license issued to that provider under the Nursing Home Care Act or the Hospital Licensing Act.

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5) "Nursing home" means a skilled nursing or intermediate long-term care facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act. However, the term "nursing home" does not include a facility operated solely as an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act.

6) "Nursing home provider" means a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long-term care facility which charges its residents, a third party payor, Medicaid, of Medicare for skilled nursing or intermediate long-term care services; or a hospital provider that provides skilled or intermediate long-term care service within the meaning of Title XVIII or XIX of the Social Security Act.

7) "Person" means, in addition to natural persons, any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

8) "Swing-beds" means those beds for which a hospital provider has been granted an approval from the federal Health Care Financing Administration to provide post-hospital extended care services (42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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1) Heading of the Part: Related Program Provisions

2) Code Citation: 89 Ill. Adm. Code 117

3) Section Number: Proposed Action:

117.80 Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, par. 12-13)[305 ILCS 5/12-13].

5) Complete Description of the Subjects and Issues Involved: The Department plans to propose rulemaking in 1995 to allow clients to receive cash benefits electronically. Individuals in cash assistance programs including Aid to Families with Dependent Children (AFDC), Aid to the Aged, Blind or Disabled (AABD), Refugee Repatriate Assistance (RRA), General Assistance (GA) and individuals receiving Child Support Enforcement pass-through payments will be enrolled in the EBT project.

EBT systems use commercial electronic credit and debit procedures to deliver human service benefits to recipients through the use of a magnetic stripe card similar to an automatic teller machine (ATM) card or a smart card with a computer chip integrated into the card. The EBT system being developed by the Department will provide clients with a plastic card similar to a bank card used at automatic teller machines (ATMs). After clients select a confidential, four-digit code they will be able to access their benefits through point-of-sale (POS) terminals or ATMs.

The advantages of EBT are the elimination of paper processing, vouchers and paper coupons, and the need for check-cashing services. Clients will use their cards to draw against their cash assistance accounts. The process will work like standard ATM withdrawals, only the money will come from a public aid account instead of a bank account. Clients purchasing food will use their cards in grocery stores and their food stamp accounts will decrease by the value of their food purchases. Clients can gain money management experience by withdrawing benefits as needed and clients will no longer have to pay check-cashing fees each month.

It is anticipated that the EBT system will improve the delivery and management of benefits. In addition, the EBT system is intended to reduce costs associated with vouchers, paper coupons, checks, check-cashing services and paper processing.

In preparation for the implementation of the EBT system, these proposed amendments allow warrants issued to protective payees to be deposited directly into a bank, savings and loan or credit union account. Under this rulemaking, individuals who are receiving payments as protective payees for recipients will be able to have the warrants deposited

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electronically. This change will enhance the security of these funds.

6) Will these proposed amendments replace emergency amendments currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendment's contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: These proposed amendments do not affect units of local government.

11) Time, Place, and Manner in which Interested Persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to Judy Umunna, Bureau of Rules and Regulations, Illinois Department of Public Aid, 100 South Grand Ave. E., 3rd Floor, Springfield, Illinois 62762 (Phone: (217) 524-3215). The Department requests the submission of written comments within 30 days after publication of this notice. The Department will consider all written comments it receives during the First Notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

12) Initial Regulatory Flexibility Analysis:

A) Date proposed rulemaking was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: Not applicable

B) Types of small businesses affected: None

C) Reporting, bookkeeping or other procedures required for compliance: None

D) Types of professional skills necessary for compliance: None

13) State reasons for this rulemaking if it was not included in either of the two most recent regulatory agendas: This rulemaking was included in the regulatory agenda published on January 13, 1995, at 19 Ill. Reg. 470.

The full text of the Proposed Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 117
RELATED PROGRAM PROVISIONS

Section
117.1 Incorporation By Reference
117.10 Payee For Financial Assistance
117.15 Reinstatement Upon Agreement to Cooperate
117.20 Replacement of Missing Warrants
117.30 Withholding of Rent (Repealed)
117.40 Recovery of Interim Assistance - Aid to the Aged, Blind or Disabled and General Assistance
117.50 Funerals and Burials
117.51 Funeral Home Services
117.52 Burial Expenses
117.53 Payment to Vendor(s)
117.54 Claims for Reimbursement
117.55 Submittal of Claims
117.60 Substitute Parental Care/Supplemental Child Care - AFDC, AABD and GA Family Cases
117.70 Charge for Replacement of Photo ID Cards (Repealed)
117.80 Direct Deposit of Recipients' Warrants
117.90 State Income Tax Match

AUTHORITY: Implementing Articles III, IV and VI and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV and VI and 12-13].

SOURCE: Filed and effective December 30, 1977; amended at 2 Ill. Reg. 31, p. 68, effective August 3, 1978; amended at 3 Ill. Reg. 38, p. 258, effective September 20, 1979; amended at 3 Ill. Reg. 41, p. 167, effective October 1, 1979; codified at 7 Ill. Reg. 5195; amended at 7 Ill. Reg. 16111, effective November 22, 1983; amended at 9 Ill. Reg. 3726, effective March 13, 1985; amended at 9 Ill. Reg. 4526, effective March 20, 1985; amended at 9 Ill. Reg. 8733, effective May 29, 1985; amended at 9 Ill. Reg. 10779, effective July 5, 1985; amended at 9 Ill. Reg. 16914, effective October 16, 1985; amended at 11 Ill. Reg. 4759, effective March 13, 1987; amended at 12 Ill. Reg. 2985, effective January 13, 1988; amended at 12 Ill. Reg. 13608, effective August 15, 1988; amended at 12 Ill. Reg. 14296, effective August 30, 1988; amended at 13 Ill. Reg. 3936, effective March 10, 1989; amended at 14 Ill. Reg. 780, effective January 1, 1990; amended at 14 Ill. Reg. 9488, effective June 1, 1990; amended at 15 Ill. Reg. 13533, effective August 29, 1991; amended at 16 Ill. Reg. 16644, effective October 23, 1992; emergency amendment at 17 Ill. Reg. 2368, effective February 8, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 8191, effective May 24, 1993; amended at 18 Ill. Reg. 3746, effective

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February 28, 1994; amended at 18 Ill. Reg. 7403, effective April 29, 1994; amended at 19 Ill. Reg. _____, effective _____.

Section 117.80 Direct Deposit of Recipients' Warrants

a) Warrants of AABD, AFDC and GA recipients shall be deposited directly into their banks, savings and loan associations or credit unions when requested by such recipients.

b) Warrants issued to Protective Payees of AABD, AFDC and GA clients are required to be deposited directly into a bank, savings and loan association or credit union account.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part:

Private Sewage Disposal Code

2) Code Citation:

77 Ill. Adm. Code 905

3)

Section Numbers:	Proposed Action:
905.10	Amendment
905.15	Amendment
905.20	Amendment
905.30	Amendment
905.40	Amendment
905.50	Amendment
905.55	New Section
905.60	Amendment
905.70	Amendment
905.80	Amendment
905.90	Amendment
905.100	Amendment
905.110	Amendment
905.120	Amendment
905.125	New Section
905.130	Amendment
905.140	Amendment
905.150	Amendment
905.160	Amendment
905.170	Amendment
905.180	Amendment
905.190	Amendment
905.200	Amendment
905.210	Repealed
APPENDIX A	
ILLUSTRATION A	Amendment
ILLUSTRATION C	Amendment
ILLUSTRATION D	Amendment
ILLUSTRATION E	
EXHIBIT A	Amendment
EXHIBIT B	Amendment
EXHIBIT C	New Section
ILLUSTRATION F	Amendment
ILLUSTRATION G	Amendment
ILLUSTRATION H	Amendment
EXHIBIT A	Amendment
EXHIBIT B	Amendment
ILLUSTRATION I	Amendment

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EXHIBIT A	Amendment
EXHIBIT C	Amendment
EXHIBIT D	Amendment
ILLUSTRATION J	Amendment
EXHIBIT A	Amendment
EXHIBIT B	Amendment
EXHIBIT C	Amendment
EXHIBIT D	Amendment
ILLUSTRATION K	Amendment
EXHIBIT A	Amendment
EXHIBIT B	Amendment
EXHIBIT C	Amendment
EXHIBIT D	Amendment
EXHIBIT E	Amendment
EXHIBIT F	Amendment
EXHIBIT G	Amendment
EXHIBIT H	Amendment
ILLUSTRATION L	Amendment
EXHIBIT A	Amendment
EXHIBIT B	Amendment
EXHIBIT C	Amendment
ILLUSTRATION M	Amendment
EXHIBIT A	Repealed, New Section
EXHIBIT B	Repealed, New Section
ILLUSTRATION N	Amendment
EXHIBIT A	Amendment
EXHIBIT B	Amendment
EXHIBIT C	Amendment
ILLUSTRATION O	Amendment
EXHIBIT A	Amendment
EXHIBIT B	Amendment
ILLUSTRATION P	Amendment
ILLUSTRATION Q	Amendment
ILLUSTRATION R	Amendment
EXHIBIT A	Amendment
EXHIBIT B	Amendment
EXHIBIT C	New Section
ILLUSTRATION S	Amendment
EXHIBIT A	Amendment
EXHIBIT B	Amendment
ILLUSTRATION T	Amendment
ILLUSTRATION U	Amendment
EXHIBIT A	Amendment
EXHIBIT B	Amendment
ILLUSTRATION V	Amendment
EXHIBIT A	Amendment
EXHIBIT B	Amendment
EXHIBIT C	New Section

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ILLUSTRATION W	Amendment
ILLUSTRATION X	Amendment

4) Statutory Authority:

Implementing and authorized by the Private Sewage Disposal Licensing Act [225 ILCS 225].

5) A Complete Description of the Subjects and Issues Involved:

The Department proposed extensive amendments to the Private Sewage Disposal Code in December of 1993. The 1993 proposed amendments went through the required public comment and second notice periods, and a public hearing was held on the rulemaking. However, the rulemaking was never adopted and was eventually withdrawn in response to an objection issued by the Joint Committee on Administrative Rules. The Department's response to the objection also included an agreement to propose the rulemaking again, using the version that was submitted to JCAR for second notice. This proposed rulemaking is identical to the version of the 1993 rulemaking that was submitted to JCAR for Second Notice. The attached proposed amendments reflect all changes made in response to comments and public hearing testimony received during the course of the 1993 rulemaking.

During the comment period and at the public hearing for the previous proposed amendments, the Department received numerous comments and suggestions regarding the rules. Many changes were made in response to these comments and the Department submitted to JCAR a version of the proposed amendments that incorporated all changes made in response to comments and public hearing testimony. In certain instances, a change suggested by a commentor was considered inappropriate for inclusion at Second Notice because the revision would result in a major substantive change to the rules without providing an opportunity for comment and discussion to all interested persons. The Department's response to such comments was that the suggestion would be considered for inclusion in a future rulemaking. Other suggestions were determined to require further discussion between the Department and industry or further study by the Department prior to inclusion in the Code. The Department responded to these suggestions with an agreement to consider the comments for inclusion in future amendments to the Code. Those suggestions that the Department agreed to consider in a future rulemaking are not addressed in this set of amendments, as this rulemaking was unforeseen at the time of the Department's response to comments on the previous rulemaking.

The subjects and issues involved in this rulemaking include the addition of new definitions for key terms to make the Code more understandable; the updating of incorporated standards; new requirements relating to the disposal of backwash water, hot tub wastewater, and floor drain wastewater; deletion of the use of a seepage pit as a method of sewage disposal; a requirement for septic tank manufacturers to record information about the delivery of septic tanks; a requirement for seepage field laterals

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connected to a distribution box to be equal in length, if not looped; a provision allowing the use of a soil investigation as an alternative to a percolation test to size a subsurface seepage system; requirements for the use of fill material; a provision for the use of sand filters on non-residential property; a provision to require a septic tank prior to a waste stabilization pond; aerobic treatment plant sizing, design, and maintenance requirements; provisions relating to the use of surface discharges and the use of effluent receiving trenches; provisions concerning the use of pumps, pumping chambers and warning devices in repairing sewage systems; requirements for the construction of portable toilets; provisions regarding removal of automotive floor drain waste to a holding tank and proper disposal of such waste; revisions concerning sanitary dump stations; revisions to examination requirements for licensure under this Code; and revision and updating of various Illustrations and Exhibits.

6) Will this Rulemaking Replace an Emergency Rule Currently in Effect? No

7) Does this Rulemaking Contain an Automatic Repeal Date? No

8) Does this Rulemaking Contain any Incorporations by Reference? No

9) Are there any other Proposed Amendments Pending on this Part? No

10) Statement of Statewide Policy Objectives:

This rulemaking may affect municipalities, counties or other units of local government.

11) Time, Place, and Manner in which Interested Persons May Comment on this Rulemaking:

A public hearing will be held on the proposed rulemaking at the following date, time and location:

April 11, 1995
10:00 a.m. - 1:00 p.m.
Bone Student Center - Circus Room
Illinois State University
Normal, Illinois 60654

The hearing will be held for the sole purpose of gathering public comment on the proposed amendments. Persons interested in presenting testimony at this hearing are advised that the Department will adhere to the following procedures in the conduct of the hearing:

1. Each person presenting oral testimony shall provide to the hearing officer a written copy of such testimony at the time the oral testimony is presented. Oral testimony will not be accepted without a written copy of the testimony being provided.

2. Persons will not be recognized to speak for a second time until all persons wishing to testify have done so. All testimony shall conclude at the specific times except that an individual in the midst of presenting testimony shall be allowed to complete his/her testimony.

3. In order to provide for a balanced presentation of views and to facilitate the orderly conduct of the hearing, the Hearing Officer may impose such other rules of procedure, including the order of call of witnesses, as he/she deems necessary.

In addition to presenting public hearing testimony, interested persons may present their comments concerning these rules by writing to Gail M. DeVito, Division of Governmental Affairs, Illinois Department of Public Health, 535 West Jefferson, Fifth Floor, Springfield, Illinois 62761, within 45 days after this issue of the Illinois Register.

These rules may have an impact on small businesses. In accordance with Sections 3.01 and 4.03 of the Illinois Administrative Procedure Act, any small business may present their comments in writing to Gail M. DeVito at the above address.

Any small business (as defined in Section 3.10 of the Illinois Administrative Procedure Act) commenting on these rules shall indicated their status as such in their comments.

12) Initial Regulatory Flexibility Analysis:

A) Type of Small Businesses Affected:

Manufacturers of septic tanks, private sewage contractors, and certified soil classifiers.

B) Reporting, Bookkeeping or Other Procedures Required for Compliance:

Manufacturers of septic tanks would be required to record information about each septic tank sold or delivered, but this information would not be required to be submitted or reported to the Department.

C) Types of Professional Skills Necessary for Compliance:

None.

13) State reason(s) for this rulemaking if it was not included in either of the two (2) most recent regulatory agendas: This was an unplanned rulemaking at the time that Regulatory Agendas were filed.

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The full text of the Proposed Amendments begins on the next page:

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TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER r: WATER AND SEWAGE

PART 905
PRIVATE SEWAGE DISPOSAL CODE

Section
905.10 Definitions
905.15 Incorporated and Referenced Materials
905.20 General Requirements
905.30 Approved Private Sewage Disposal Systems
905.40 Septic Tanks
905.50 Distribution Boxes
905.55 Subsurface Seepage System Design Requirements
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AUTHORITY: Implementing and authorized by the Private Sewage Disposal Licensing Act [225 ILCS 225].

SOURCE: Filed October 19, 1974, effective October 25, 1974; rules repealed, new rules adopted at 6 Ill. Reg. 3095, effective March 9, 1982; amended at 8 Ill. Reg. 8552, effective June 4, 1984; codified at 8 Ill. Reg. 19821; amended at 9 Ill. Reg. 20738, effective January 3, 1986; amended at 10 Ill. Reg. 11054, effective July 1, 1986; amended at 19 Ill. Reg. _____, effective _____.

Section 905.10 Definitions

In addition to the definitions contained in the Private Sewage Disposal Licensing Act ~~(Ill. Rev. Stat. 1983, ch. 111 1/2, pars. 116.301 et seq.)~~ [225 ILCS 225], the following definitions shall apply:

"Aerobic Treatment Plant" means equipment or devices for the treatment of sewage by the forced addition of air or oxygen.

"Ag. Experiment Station" means the University of Illinois Agricultural Experiment Station.

"Approved" or "Approval" means accepted by or acceptable to the Department or local authority.

"ASTM" means the American Society for Testing and Materials.

"Building Sewer" means that part of the horizontal piping of a drainage system which extends from the end of the building drain, receives the discharge of the building drain and conveys it to a public sewer, private sewer, individual sewage disposal system, or other point of disposal. The building sewer commences ~~five~~ 5 feet outside the building foundation wall.

"Common Collector" means an underground, enclosed conduit designed to carry treated sewage effluent exclusive of stormwater from 3 or fewer properties provided the combined treated sewage effluent is less than 1500 gallons per day and has a surface discharge. An example of a common collector is a solid plastic pipe installed to carry treated sewage effluent from 2 or 3 discharging systems with a combined design flow of less than 1500 gallons per day. Examples of what is not a

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common collector are road ditches, field ditches, curbs and gutters, grassed waterways, concrete or other lined drainage ways.

"Effluent Receiving Trench" means a seepage line of gravel or gravelless design used to receive the treated discharge from an aerobic treatment plant, sand filter, or lagoon prior to discharge to the ground surface or other location.

"Effective Size" means the size of screen opening where 90 percent by weight of a sample of filter media is retained on the screen and 10 percent passes through the screen.

"Gravelless Seepage System" means the use of approved perforated 8 inch or 10 inch diameter, filter wrapped, plastic pipe, used in lieu of 4 inch pipe and gravel in subsurface fields and serial distribution systems.

"Hot Tub" means an artificial container of water with a liquid capacity greater than 100 gallons and designed with a mechanical air injection system and/or recirculating device. These devices may filter and/or disinfect the water for reuse and are not intended to be drained between uses.

"Limiting Layer" means a horizon or condition in the soil profile or underlying strata which includes:

A seasonal high water table, whether perched or regional, determined by direct observation of the water table or indicated by soil mottling where common mottles comprise at least 2% to 20% of the soil, in a progressive downward direction in the soil.

Masses of loose rock fragments, including gravel, with insufficient fine soil to fill the voids between the fragments.

Rock formation, other stratum or soil condition which is so slowly permeable that it effectively limits downward passage of effluent.

"Liquid Capacity" means the volume of a tank below the invert of the outlet line.

"Local Authority" means a local unit of government which enforces a private sewage disposal ordinance which has been approved by the Department; or a local health department which has been designated an agent of the State for conduct of the Private Sewage Disposal Program.

"Non-Residential Property" means any property which is not residential property.

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"NSF" means the National Sanitation Foundation, an independent testing laboratory.

"Residential Property" means a single family home or multi-family unit intended for occupation as living quarters, which is not used to conduct any business that generates wastewater or domestic sewage.

"SCS" means the USDA Soil Conservation Service.

"Septage" means the solid and liquid wastes removed from private sewage disposal systems.

"Shall" means the stated provision is mandatory.

"Soil Boring" means an observation pit, dug by hand or backhoe, or an undisturbed soil core taken intact and undisturbed by a probe.

"Soil Classifier" means one of the following:

A certified soil classifier of the Illinois Soil Classifiers Association (ISCA) or a certified soil classifier with the American Registry of Certified Professionals in Agronomy, Crops and Soils (ARCPACS).

A person who is a full member or associate member of the Illinois Soil Classifiers Association (ISCA) provided that direct supervision is provided to this person by an ISCA or ARCPACS certified soil classifier who accompanies the person on at least 25% of the soil investigations and reviews and signs all of that person's soil investigation reports.

"Subsurface Seepage System" means a subsurface seepage field, seepage bed, ~~seepage--pit,~~ or an 8" or 10" ~~gravel-less~~ gravelless seepage ~~bed~~ system.

"Uniformity Coefficient" means a number obtained by dividing that size of sand in millimeters of which 60 ~~percent~~% by weight is smaller, by that size of sand in millimeters of which 10 ~~percent~~% by weight is smaller.

"Wastewater Source" means any equipment, facility, or other source of any type whatsoever which discharges wastewater, directly or indirectly to the waters of the State.

"Water Table" means the upper limit of the portion of the soil which is completely saturated with water. The seasonal high water table is the highest level to which the soil is saturated, as may be indicated by mottling (soil color patterns).

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Soil science terms used throughout the text of this Code are defined in the Glossary of Soil Science Terms (July 1987) unless otherwise defined.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.15 Incorporated and Referenced Materials

a) ~~The--following--federal--and--state-regulations,-standards,-and-statutes-are incorporated-or-referenced-in-various-sections--of--this--part:~~ The following standards and federal regulations are incorporated by reference in this Part:

1) National Sanitation Foundation, Criteria C-9, Evaluation of Special Processes, Components, or Devices Used in Treating Wastewater ~~(1983)~~ (1990) and published by:
The National Sanitation Foundation
3475 Plymouth Road, P.O. Box 1468
Ann Arbor, Michigan 48106.
Referenced in Section 905.30

2) ANSI/NSF International ~~National-Sanitation-Foundation~~, Standard Number 40, Individual Aerobic Wastewater Treatment Plants (July 1990 ~~1983~~) and published by:
NSF International ~~The-National-Sanitation-Foundation~~
3475 Plymouth Road, P.O. Box 1468
Ann Arbor, Michigan 48106.
Referenced in Section 905.100

3) National Sanitation Foundation, Standard Number 41, Wastewater Recycle/Reuse and Water Conservation Devices (1990 ~~1983~~) and published by:
The National Sanitation Foundation
3475 Plymouth Road, P.O. Box 1468
Ann Arbor, Michigan 48106.
Referenced in Section 905.130

~~4) Private-Sewage-Mound-Code-(77-Ill.-Adm.-Code-906).--Referenced-in Section-905.30~~

~~A) Requirements--for-the-Design-of-Wisconsin-Mounds-in-Illinois (1983)-Illinois-Department-of-Public-Health:~~

~~i) PART-I-of-this--Manual--is--taken--from--the--material printed--in--the--"Design--and-Construction-Manual-for Wisconsin-Mounds",-September-1978.~~

~~ii) PART-II-of-this-Manual-is-reprinted-from--the--"Design of-Pressure-Distribution-Networks-for-Septic-Tank-Soil Absorption---Systems,"--January--1981,--University--of Wisconsin.~~

~~B) Parts-I-and-II-are-published-by:~~
~~Small-Scale-Waster-Management-Project~~
~~University-of-Wisconsin~~
~~Madison,-Wisconsin-53706.~~

4)~~5)~~ American Society for Testing and Materials (ASTM) required standard are listed under Section 905.Appendix A of this Part ~~Illustration-C~~. List of approved plastic pipe for ~~septic~~ private sewage disposal system uses, and ~~standard~~ Standards may be obtained from:
American Society for Testing and Materials
1916 Race Street
Philadelphia, PA. 19103
Referenced in Section 905.40, 905.60, 905.70

~~6) Illinois--Plumbing--Code--1983--(77--Ill.-Adm.-Code-890)-Illinois Department-of-Public-Health.~~

~~7) Recreational--Area--Rules--(77--Ill.--Adm.--Code--800)---Illinois Department-of-Public-Health.~~

~~8) Rules--of--Practice--and-Procedure-in-Administrative-Hearings-(77 Ill.-Adm.-Code-100)-Illinois-Department-of-Public-Health.~~

5) Standard Methods for Examination of Water and Wastewater and published by:
American Public Health Association
1015 8th Street
Washington, D.C. 20036
Referenced in Section 905.110

6) Glossary of Soil Science Terms (July 1987) and published by:
The Soil Science Society of America
677 South Segoe Road
Madison, Wisconsin 53711

7) Title 40 of the Code of Federal Regulations, Standards for the Use or Disposal of Sewage Sludge (40 CFR 503)
Referenced in Section 905.170

8) National Electrical Code, 1993 Edition, published by:
National Fire Protection Association
Batterymarch Park
Quincy, Mass. 02269
Referenced in Section 905.20

b) The following State regulations are referenced in this Part:

1) Department of Public Health regulations

A) Private Sewage Mound Code (77 Ill. Adm.Code 906)
(Referenced in Section 905.30.

B) Illinois Plumbing Code (77 Ill. Adm. Code 890)
Referenced in Sections 905.140, 905.150 and Appendix A: Illustration C of this Part

C) Recreational Area Code (77 Ill. Adm. Code 800)
Referenced in Section 905.150.

D) Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100)

2) Pollution Control Board regulations

A) Introduction (35 Ill. Adm. Code 301)
Referenced in Section 905.110

B) Permits (35 Ill. Adm. Code 309)
Referenced in Sections 905.110 and 905.170

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C) Outline of Waste Disposal Regulations (35 Ill. Adm. Code 700)
Referenced in Sections 905.20 and 905.140

c)~~b)~~ All incorporations by reference of federal regulations and the standards of nationally recognized organizations refer to the regulations and standards on the date specified and do not include any additions or deletions subsequent to the date specified.

d)~~c)~~ All citations to federal regulations in this Part concern the specified regulation in the 1994 ~~1986~~ Code of Federal Regulations, unless another date is specified.

e)~~d)~~ All materials incorporated by reference are available for inspection and copying at the Department's Central Office, Division of Environmental Health, ~~535~~ 525 West Jefferson, Springfield, Illinois 62761.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.20 General Requirements

a) Rate of Flow for Domestic Sewage. Each unit of the private sewage disposal system shall be designed to treat the volume of domestic sewage discharged to it. The volume of sewage flow shall be determined from Appendix A~~:~~ Illustration A of this Part. For non-residential establishments, the Department will consider the use of actual flow volumes obtained from similar installations in lieu of the quantities contained in Appendix A~~:~~ Illustration A of this Part, when the flow data is documented. Examples of the documentation that could be accepted would be actual measurements of the quantity of wastewater, or water use receipts. In the design of a private sewage disposal system, peak flows shall be designed for, and/or attenuated. When the sewage flow exceeds 1500 gallons per day, and there is a surface discharge, then approval shall be obtained from the Illinois Environmental Protection Agency.

b) Type of Waste. A private sewage disposal system shall be designed to receive all waste ~~domestic--sewage~~ from the buildings served. No cooling water, groundwater, discharge from roof drains, discharge from footing tile drains, swimming pool wastewater, or other clear water discharges shall be directed to the private sewage disposal system. Waste products such as automotive grease, oils, solvents, and chemicals shall not be discharged to a private sewage disposal system. These waste products shall be handled according to the rules of the Pollution Control Board entitled "Outline of Waste Disposal Regulations" (35 Ill. Adm. Code 700). Drains or fixtures receiving any product other than domestic sewage shall be discharged to a holding tank and not to a private sewage disposal system. ~~No automotive-grease-or-oil,-or-toxic-wastes,-or--any--waste--other--than domestic-waste-shall-be-discharged-to-a-private-sewage-system.~~

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1) Backwash water from a water softener shall discharge to one of the following:
   A) A septic tank followed by a seepage field, sand filter or lagoon.
   B) A separate subsurface seepage system, provided the seepage field is designed to accommodate the flow from this device on a daily basis. A septic tank is not required in front of a seepage field receiving flow from this device.

2) Hot tub wastewater. Wastewater generated by a hot tub or other similar device shall be discharged to one of the following:
   A) A separate subsurface seepage system, provided the seepage field is designed to accommodate the liquid capacity of the hot tub on a daily basis. A septic tank is not required in front of a seepage field receiving flow from this device.
   B) The seepage field serving the domestic wastewater flow, provided the seepage field is increased in size to accommodate the additional flow from the hot tub on a daily basis. This drainage shall be piped around the septic tank and directly into the seepage field.

c) Individual Service. The use of a private sewage system to serve more than one property is prohibited except where a common property is provided, under joint ownership of the users, or where the system is under public jurisdiction or managed by a district established for the maintenance of such systems.

d) Water and Sewer Line Separation. The following criteria shall govern the separation of water supply lines and sewer lines:
   1) Horizontal Separation. Sewers shall be installed at least 10 feet horizontally from any existing or proposed water line. When local conditions prevent a lateral separation of 10 feet, a sewer may be laid closer than 10 feet to a water line provided that the elevation of the crown of the sewer is at least 18 inches below the invert of the water line.
   2) Crossings. Where sewer lines must cross water lines, the sewer line shall be laid at such an elevation that the crown of the sewer line is at least 18 inches below the invert of the water line. This vertical separation shall be maintained for that portion of the sewer line located within 10 feet horizontally of any water line it crosses. When sewer lines must cross above water lines, the sewer lines shall be Schedule 40 or equivalent material ~~and~~ with ~~water-tight~~ watertight joints.

e) Sanitary Sewer. New or renovated private sewage disposal systems shall not be approved where a ~~public~~ sanitary sewer operated and maintained under permit of the Illinois Environmental Protection Agency is available for connection. A sanitary ~~public~~ sewer is available for connection when it is within 200 feet of a residential property or a non-residential property with a sewage flow less than 1500 gallons per day, or within 1000 feet of a non-residential property with a sewage flow greater than or equal to 1500 gallons per

day ~~the property~~ unless a physical barrier or local ordinance exists which prevents connection to the sewer. It is not the intent for an individual to subsidize the extension costs of a sanitary sewer system; therefore only an individual connection with an individual line will be required.

f) Acceptable Pipe Materials.

1) All piping located more than ~~five~~ 5 feet from the building foundation, used to convey wastewater to a private sewage disposal system, shall be considered a part of the private sewage disposal system and shall be watertight. This ~~All~~ piping ~~located from a point five feet from the building foundation to a point six feet beyond the septic tank (or distribution box where used)~~ shall be ductile iron, vitrified clay, ~~asbestos cement,~~ or plastic pipe. Only vitrified clay or plastic pipe shall be used from the septic tank and after the distribution box (where used). Perforated pipe or open-jointed tile shall be used only as provided in this Code.

2) Use of plastic pipe and fittings shall conform to the uses designated in Appendix A: ~~e~~ Illustration C of this Part.

3) Piping used to carry domestic sewage under areas such as driveways, roads, or parking areas shall be Schedule 40 equivalent or greater.

g) Pipe Size and Slope. All solid pipes carrying domestic sewage by gravity flow shall have ~~an~~ a nominal ~~inside~~ diameter of at least ~~four~~ 4 inches and a minimum slope of 12 inches per 100 feet. Solid header lines used for equal distribution shall be level.

h) Prohibited Discharges. There shall be no discharge of raw or improperly treated domestic sewage to the surface of the ground or to farm tiles, streams, rivers, ponds, lakes, or other collectors of water. Improperly treated domestic sewage is sewage that does not meet the effluent requirements of Section 905.110(b) or sewage which comes directly from a septic tank or building sewer. Domestic sewage or effluent from any private sewage disposal system or component shall not be discharged into any well, cistern, basement or into any underground mine, cave, sinkhole or tunnel.

i) Pipe Length. Building sewers in excess of 50 feet in length which carry wastewater from the buildings served to the septic tank, distribution box or aeration treatment plant shall be provided with at least one clean-out every 50 feet that terminates at grade.

j~~i~~) Private Sewage Disposal System Development. The following factors shall govern the development of a private sewage disposal system:

1) Drainage. A private sewage disposal system shall not be located in areas where surface water will accumulate. Provisions shall be made to minimize flow of surface water over the private sewage system. Examples of such provisions would be the use of dikes, embankments, ditches or flow diverters.

2) Distances. The location of the various components of a private sewage disposal system shall comply with Appendix A: Illustration D of this Part.

3) Area Reserved for Sewage Disposal. The area to be used for a private sewage disposal system shall be selected and maintained so that it is free from encroachment by driveways, accessory buildings, swimming pools, parking areas, buried lawn sprinkling systems and underground utility services, patios, slabs, additions to the original structure or any other structure which limits free access to the system for maintenance, servicing or proper operation.

~~4) Water Table; Subsurface seepage systems should not be constructed in areas where the groundwater table is within four feet of the bottom of the trench or the bed;~~

45) Creviced Limestone Formations. A subsurface seepage system shall not be constructed in an area where there is less than ~~four~~ 4 feet of soil between the lowest point in a subsurface seepage system and the top of a received limestone formation. In areas where creviced limestone is known to occur, a soil boring ~~or backhoe excavation~~ to a depth of at least ~~four~~ 4 feet below the bottom of the subsurface seepage system shall be made to verify that creviced limestone is not present.

k~~j~~) Electrical ~~Warning~~ Devices. Any component of a private sewage disposal system which is electrically activated shall be provided with a visible and audible warning device placed within the building served. All electrical devices shall be wired in accordance with the National Electrical Code or a municipal, county, or local electrical code, whichever is more stringent.

l~~k~~) Variances. If conditions exist at a proposed installation which make impractical or impossible compliance with the requirements of this Part, a variance may be requested by submitting to the Illinois Department of Public Health, Division of Environmental Health ~~Division of Engineering and Sanitation at 535 West Jefferson Street, Springfield, Illinois 62761~~, or appropriate local authority a written proposal which is to be used in lieu of compliance with this Part. Such written request shall include pertinent data such as soil conditions, water table elevations, drainage patterns and distances to water supplies in order to support the request. The capability of the system to comply with the intent of this Part will be the basis for approval or denial of the variances. The Department or local authority will notify the applicant in writing of its decision to either grant or deny the variance. A variance shall be requested and approved before construction begins.

m~~l~~) Experimental Use Permits. If a private sewage disposal system or component is of a new and/or innovative type and does not comply with the requirements of this Code, the homeowner or private sewage contractor may request an experimental use permit. Such a request shall be submitted in writing to the Illinois Department of Public Health, Division of Environmental Health ~~Division of Engineering at 535 West Jefferson Street, Springfield, Illinois 62761~~, like prior to

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construction or installation, and shall meet the following requirements:

1) The request shall specify the type of proposed system or component to be used and be accompanied by plans, specifications, and engineering data to support the system's compliance with the general requirements under Section 905.20 and with the effluent criteria under Section 905.110 for surface discharges, if applicable.

2) Information (such as topographical or plat maps) regarding the location of each installation shall be provided to the Department.

3) The homeowner, private sewage disposal system installation contractor, and/or manufacturer shall provide the Department with proof that area is available for installation of an approved system should the experimental system fail.

4) The homeowner, private sewage disposal system installation contractor, and/or manufacturer shall guarantee in writing the replacement of the experimental system with an approved system if the experimental system fails to perform in accordance with any of the Sections of this Part, or with criteria established as a condition to approval of the system.

5) The private sewage disposal system installation contractor and/or the manufacturer shall notify the homeowner or the person obtaining the experimental use permit, of the aforementioned guarantee, and of the minimum standards of the Illinois Private Sewage Disposal Code which must be met.

~~6) The Department will issue an experimental permit for new systems designed and intended to discharge directly to the surface, pursuant to Section 905.20(m), when the system has been approved by National Sanitation Foundation (N.S.F.) in accordance with N.S.F. Criteria C-9 (1983).~~

nm) Experimental Use Evaluation. Upon receipt of the above information, the Department will review the experimental system to determine the system's capability of being considered equal to or more stringent than, applicable Sections in this Code, and will notify the applicant, in writing, of its decision to grant or deny the request. If approved, the Department will issue an "Experimental Use Permit" for each installation up to 30 ~~50~~ installations in the State. A minimum of 10 ~~five~~ such installations shall be evaluated before an unconditional approval may be granted. The experimental permit shall be valid for a ~~maximum~~ period of ~~two~~ 2 years, during which time, the Department will evaluate the performance of the experimental system. At the end of the ~~two~~ 2 year evaluation period, the Department will make a determination as to the system's acceptability. The system will be deemed unacceptable when sewage erupts from the ground, ~~or~~ effluent from the system does not meet the criteria of Section 905.110(d)~~(b)~~ or the system does not meet requirements previously set by the Department. If acceptable, the experimental system shall become an approved private sewage system. If found to be unacceptable, the experimental system shall not be approved for use as a private sewage disposal system and shall be replaced with an approved private sewage disposal system. The Department shall notify the applicant in writing of its final determination.

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o) Garbage Grinders. When garbage grinders are used in residential property, solids shall be retained by one of the following methods:

1) A solids retention tank constructed in accordance with Section 905.40 shall be placed between the wastewater source and the septic tank to intercept solids from the garbage grinder. This tank shall receive waste from the garbage grinder(s) or the kitchen wastes only. No other fixtures shall discharge into this tank. The solids retention tank shall be at least 50% in liquid volume of the septic tank sized for the waste from the rest of the property, however, the minimum size tank to be used shall be 500 gallons.

2) A septic tank receiving all flows from the property sized in accordance with Appendix A: Illustration F of this Part.

p) Whenever an existing private sewage disposal system is repaired or replaced, that portion of the system being repaired or replaced shall comply with all the requirements of this Part.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.30 Approved Private Sewage Disposal Systems

~~a) General:~~

~~1)~~a) The following systems are approved for private sewage disposal when designed, constructed, operated, and maintained in accordance with this Code:

1)~~A)~~ Septic tank or Imhoff tank followed by:

~~i)~~A) Subsurface seepage field

~~ii)~~B) Seepage bed

~~iii) Seepage pit~~

~~iv)~~C) Sand filter (buried or recirculating)

~~v)~~D) Waste stabilization pond

E) 8 inches or 10 inches gravelless seepage system

2)~~B)~~ Aerobic treatment plant discharging to supplementary treatment or to the surface, as provided in Section 905.100 and 905.110.

~~C) Waste stabilization pond:~~

3)~~D)~~ Privies, chemical toilets, recirculating toilets, incinerator toilets, compost toilets.

4)~~E)~~ ~~Wisconsin~~-Mounds designed in accordance with the requirements of ~~for~~ the ~~Design of Wisconsin Mounds in Illinois~~ Private Sewage Mound Code, ~~1983 Edition~~ (77 Ill. Adm. Code 906).

5) Holding tanks installed in accordance with Section 905.140.

6)~~F)~~ Any other system for which a variance in accordance with Section

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905.20~~(k)~~(l) has been issued or for which an experimental permit in accordance with Section 905.20~~(l)~~(m) has been issued.

~~2)~~b) All other systems or components are not approved.

~~b) System--Approval.---Installation--of--systems--which-are-not-listed-in Section-905.30(a)-and-which-are-designed-for--surface--discharge--will only--be-allowed-when-such-systems-are-in-accordance-with-the-National Sanitation-Foundation-Standard-C-9-(1983).~~

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.40 Septic Tanks

a) Septic Tank Approval. Manufacturers of prefabricated septic tanks shall submit ~~three~~ 3 sets of plans for each size and configuration of septic tank to the Department for approval. Such plans shall be drawn to scale and show all dimensions, baffles, tees, cleanouts, and material specifications. A written approval for each size tank shall be provided by the Department when the plans are found to conform to the requirements of this Code.

1) The Department shall issue an approval number to each manufacturer for each series of approved septic tanks, and shall maintain a listing of the approved manufacturers and approved septic tank series.

2) No prefabricated septic tank shall be sold, offered for sale, or installed other than those which have been approved by the Department. The tank shall bear the manufacturer's approval number and the liquid capacity of the tank, in gallons~~,~~ prominently displayed on the outside end wall of the tank above, or next to, the outlet pipe so that this information is readily visible after installation and prior to covering. The Illinois Department of Public Health approval number shall not be used on any tank other than the septic tank for which it is has been issued.

3) All persons who manufacture, sell, offer for sale or deliver septic tanks or aerobic treatment plants in or into the State of Illinois shall record the following information about each septic tank or aerobic treatment plant sold or delivered. This information shall be available for inspection by the Department or local authority upon request.

A) Name of purchaser and/or property owner (if different)

B) Location of delivery (county and address, legal description or driving directions)

C) Date of sale and delivery

D) Size of septic tank or model of aerobic unit

b) Septic Tank Construction. Septic tanks shall be designed and constructed in accordance with the following: (Appendix A~~,~~: Illustration E of this Part is an illustration of these requirements)

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1) A septic tank shall be watertight and constructed of sound and durable materials not subject to excessive corrosion, decay, frost damage, or cracking due to settling or ~~back-filling~~ backfilling.

2) Engineering Specifications.

A) The tank shall support a top-dead load of not less than 500 pounds per square foot, and concrete tanks shall have a minimum 28-day compressive strength of 3000 pounds per square inch (psi).

B) Tanks must be designed and constructed so that they will not collapse or rupture when subjected to anticipated earth and hydrostatic pressures when the tanks are either full or empty. The manufacturer, design engineer, and/or structural engineer shall certify in writing to the Department that the tank is designed and constructed to meet the load requirements of this Part. If additional loading is anticipated, the tank shall be strengthened to accommodate the additional loading.

3) Materials. Septic tanks shall be constructed of the following approved materials:

A) Poured-in-place reinforced concrete.

B) Precast reinforced concrete.

C) Concrete block, provided that the core is filled with concrete and reinforcing rods are inserted in the core prior to pouring.

D) Reinforced plastic.

E) Reinforced fiberglass.

F) Thermoplastic.

4) Depth. The minimum liquid depth of the tank shall be 42 inches, and the maximum liquid depth shall be 72 inches.

5) Inlet and Outlet Connections.

A) The invert elevation of the inlet shall be at least ~~two~~ 2 inches above the liquid level in the tank.

B) The inlet and outlet openings of the septic tank shall be provided with cast-in watertight openings.

6) Baffles. Septic tank baffles shall meet the following requirements:

A) Inlet baffles shall be provided and shall extend at least 6 inches below the surface of the liquid.

B) Inlet baffles shall be located no farther than 12 inches from the inlet orifice.

C) Inlet and outlet baffles shall have a clearance of at least one inch but not greater than 3 inches of free space between the underside of the tank lid and the baffles.

D) Outlet baffles shall be provided and shall extend to a depth of 40% of the liquid depth.

E) Outlet baffles shall be located no farther than 6 inches from the outlet end wall.

F) Slip-in baffles shall extend the full width of the tank.

G) The sides of "V" or semi-circular type baffles shall fit tightly against the end wall of the tank.

H) Venting shall be provided through all baffles and a free vent area equal to the cross-sectional area of the house sewer shall be provided.

I) Submerged pipe T-branches or sanitary tees may be used at the inlets and outlets in lieu of baffles, provided all of the above stated distances and depths are maintained.

J) Submerged pipe T-branches or sanitary tees used as inlet baffles shall be 6 inches in diameter or larger. Outlet baffles shall be 4 inches in diameter.

K) Submerged pipe T-branches or sanitary tees shall meet the requirements of ASTM 2661, ASTM 2665 or ASTM 3034, ASTM 3033, or ASTM 2751 provided the pipe does not have an SDR (Standard Dimension Ratio) number greater than 35.

L) When submerged pipe T-branches or sanitary tees are used as baffles, it shall be the responsibility of the septic tank manufacturer to assure proper location of components during initial installation.

M) When a single compartment septic tank is manufactured or used, a gas deflection baffle shall be provided below the outlet baffle of the tank configured to deflect rising gas bubbles away from the outlet structure and toward the interior of the tank. This baffle shall be constructed of a durable material not subject to corrosion or decay. (Appendix A: Illustration E, Exhibit C of this Part is an illustration)

6) ~~Baffles.--Inlet baffles shall be provided--and--shall--extend--at least six inches below the surface of the liquid and to within at least--three--inches--of--the--tank lid.--Outlet baffles shall be provided and shall be located no farther than six inches from the outlet orifice.--Outlet baffles shall extend to--a--depth--of--at least 40 percent of the liquid depth.--There shall be a clearance of--at--least--one inch of free space between the top of the tank and the baffles.--Slip-in type--baffles--shall--extend--the--full width--of--the--tank.---The--sides--of--"V"--or semi-circular type baffles shall fit tightly against--the--end--wall--of--the--tank. Venting--shall--be--provided through all baffles.--Submerged pipe T-branches or sanitary tees may be used at inlets and outlets--in lieu--of--baffles, provided all of the above stated distances and depths are maintained.~~

7) Access. Access shall be provided over the inlet and outlet of the tank to facilitate inspection and cleaning. The manhole or access opening shall have a fitted lid with a minimum dimension of 12 inches (width or diameter). Risers shall be watertight and constructed of a durable material. If the top of the tank is greater than 12 inches below the ground surface, a riser with a minimum dimension of 12 inches (width or diameter) shall be provided to bring access over the inlet and outlet to within 12 inches of the ground surface. The joint between the septic tank and the riser(s) shall be watertight. ~~A manhole or access port extention collar or riser with a minimum dimension (width or diameter) of 12 inches shall be provided by the private sewage disposal contractor to bring access to the tank to within twelve inches of the ground surface.~~ If a 2 compartment tank is used, the opening over the wall between the compartments shall have access provided within 12 inches of the ground surface.

c) Capacity.

1) Septic tanks for individual residences shall be sized in accordance with Appendix A~~,~~: Illustration F of this Part. Septic tanks for any establishment other than residential property ~~units~~ shall be sized in accordance with the estimated flow provided in Appendix A~~,~~: Illustration A of this Part and as follows:

2) The volume below the liquid level for flows up to 500 gallons per day shall be at least 750 gallons. For flows greater than 500 gallons per day ~~and less than 1500 gallons per day,~~ the volume shall be equal to at least one and one-half times the estimated daily sewage flow. ~~For flows greater than 1500 gallons per day, but less than 14,500 gallons per day, the volume shall be 1,125 gallons plus 75 percent of the daily sewage flow. For flows in excess of 14,500 gallons per day, the Department or local authority shall be consulted in order to assure that problems do not exist in the disposal of large flows and to determine whether or not the system would be regulated by Illinois Environmental Protection Agency Regulations.~~ When the total flow exceeds 1,350 gallons per day, ~~two~~ 2 or more tanks in series, or a multi-compartment tank, shall be installed.

d) Multiple Tanks or Compartments. When multiple compartment septic tanks or multiple septic tanks in series are used, the capacity of the first compartment or tank shall be one-half to two-thirds of the total required capacity. Two compartment tanks shall also comply with the following:

1) The wall separating the first and second compartments shall be tight-fitting and designed to handle the differential in pressure if one side is pumped.

2) The wall separating the compartments shall extend to within 3 inches of the tank lid and shall have a free vent area equal to the cross-sectional area of the house sewer.

3) The center of the opening between compartments shall be in line with the center of the inlet and outlet openings.

4) The depth to the invert of the opening between compartments shall be 40% of the liquid depth.

5) A gas deflection baffle shall be provided below the outlet baffle of the tank configured to deflect rising gas bubbles away from

the outlet structure and toward the interior of the tank. This baffle shall be constructed of a durable material not subject to corrosion or decay.

6) An access opening at least 18 inches in minimum dimension shall be provided over the wall separating the 2 compartments.

e) Septic Tank Installation.

1) The septic tank shall be set level and backfilled to prevent floatation or drifting of the tank. Level shall mean plus or minus one-half inch in any direction (length or width or diameter of the tank). ~~Septic Tank--Installation.---The--contractor--shall fill--the--septic--tank-with-water-immediately-after-being-set-in the-proper-position-and-back--filled--to--prevent--floatation--or drifting,-unless-the-tank-is-being-installed-in-dry-soil.~~

2) If the inlet, outlet or access openings are to be set at or below the seasonal high water table, all openings in the tank shall be made watertight using mastic, tar, silicone caulk, etc.

3) There shall be no connections such as joints, splices, or fittings within the area of overdig around the septic tank.

f) Abandoned Treatment Units ~~Septic Tanks~~. Septic tanks, cesspools, pit privies, aerobic treatment plants and seepage pits which are no longer in use shall be completely pumped. The floor and walls shall be cracked or crumbled so the tank will not hold water and the tank shall be filled with sand or soil~~.~~. If the tank is removed from the ground the excavation shall be filled with soil.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.50 Distribution Boxes

a) General. Distribution boxes may be installed between a septic tank or aerobic treatment plant and a subsurface seepage system or buried sand filter. If a distribution box is used, it shall be installed level on unexcavated earth, and shall provide equal distribution of flow to the subsequent disposal system.

b) Connecting Pipe. The pipe connecting the septic tank to the distribution box and the pipe connecting the distribution box to the disposal system shall be watertight.

c) Construction. Distribution boxes shall be constructed of a durable watertight, non-corrosive material. They shall be designed to accommodate the necessary distribution lines.

d) Access. Distribution boxes shall be provided with an opening which will serve as a ready access for inspection, cleaning, and general maintenance.

e) There shall be no connection such as joints, splices or fittings within the area of the overdig around the distribution box.

(Source: Amended at 19 Ill. Reg. _____, effective

_____)

Section 905.55 Subsurface Seepage System Design Requirements

When designing a subsurface seepage system the absorption capacity of the soil shall be determined by subsection (a) or (b) of this Section as follows:

a) Soil Investigation

1) Soil investigations shall be conducted in the following manner:

A) Determination of soil characteristics on sites proposed for development with private sewage disposal systems shall be based on soil boring data collected by a soil classifier or an Illinois licensed professional engineer.

B) There shall be a minimum of 3 borings per soil absorption system site. The soil borings shall be at least 50 feet apart and the proposed subsurface seepage system shall be located within the area where the soil borings were located. More soil borings may be necessary for accurate and appropriate evaluation of a site where there is some concern about the consistency of the soil materials. One of the borings shall be made at the lowest elevation of the proposed absorption field area. Borings shall extend a minimum of 60 inches below the natural ground surface. An observation pit shall be used in gravelly materials.

C) Observation and determination of soil characteristics may be also determined from a pit dug by a backhoe or other excavating equipment. The Department or local authority may require soil pits (backhoe excavation) in cases where ground is frozen, where the soil materials are considerably varied in texture, where there has been previous or current fill material, cutting of soils, or where gravelly soils are encountered. Such soil pits shall be prepared at the perimeter of the expected soil absorption area to minimize damage to natural soil structure. Soil pits shall extend a minimum of 60 inches below the natural ground surface.

D) Site characteristics to be described include zones of seasonal and permanent water saturation, U.S.D.A. soil textural changes, U.S.D.A. soil structural features, slope, compaction and depth, soil coloration, depth of limiting layer, depth of soil mottling (depth to low chroma equal to or less than 2 and a value of 4 or more - Munsell Color System), internal drainage classification, and permeability range, and other limiting soil characteristics that may reduce permeability.

2) Only those persons who meet the definition of soil classifier or a licensed professional engineer are qualified to conduct soil investigations. A list of qualified persons will be available from the Department upon request.

3) If conflicting soils investigation information is provided about

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a given site, an SCS soil scientist may be requested to provide professional information.

b) Percolation Tests.

1) Performance of Percolation Tests. At least 3 separate percolation tests, a minimum of 50 feet apart, shall be performed at the site of each proposed subsurface seepage system.

2) Procedure for Performing Percolation Tests. Percolation tests shall be performed in accordance with the procedure outlined in Appendix A: Illustration G of this Part. Alternate procedures for performing percolation tests may be submitted to the Department for review. If determined to be as stringent as that described in Appendix A: Illustration G of this Part, the alternate procedure shall be approved.

3) If soils information, permits for private sewage disposal systems in close proximity to the proposed site, direct observations or other information show conditions which will impact the design, construction, installation, modification or performance of the private sewage disposal system, the Department or local authority shall determine the seasonal high water table, fill, soil compaction, poor soil structure, high bulk density, dense unleached glacial till, fragipans, sodic horizons or other limiting soil characteristics that may reduce permeability or impact on design, construction or location of a subsurface seepage system.

(Source: Added at 19 Ill. Reg. _____, effective _____)

Section 905.60 Subsurface Seepage System Construction Requirements

~~a) Evaluation of Soil Characteristics. The absorption capacity of the soil shall be determined from the results of percolation tests. The area of a subsurface seepage system shall be sized based upon percolation tests (Appendix A: Illustrations G and H). Where allowed by a local authority with an approved Private Sewage Disposal ordinance, soil classification information may be used in conjunction with or in lieu of percolation tests. Written percolation tests shall be available on the construction site.~~

~~b) Performance of Percolation Tests. At least two separate percolation tests, a minimum of 50 feet apart, shall be performed at the site of each proposed subsurface seepage system. The private sewage contractor shall be responsible for the percolation test results, and the sewage system which is designed using those results. Acceptance of percolation test results from other sources does not relieve the contractor's responsibility.~~

~~c) Procedure for Performing Percolation Tests. Percolation tests shall be performed in accordance with the procedure outlined in Appendix A: Illustration G. (Department Circular 4.005E) Alternate~~

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~~procedures for performing percolation tests may be submitted to the Department for review. If determined to be as stringent as that described in Appendix A: Illustration G, they shall be approved.~~

~~d) Construction. Subsurface seepage fields shall be designed and constructed in accordance with Appendix A: Illustrations H, I and J.~~

~~e) Bedding Material. The bedding material which is free of mud, silt, or clay, shall be clean gravel or clean stone with particle size ranging from 3/4 inch minimum to four inches maximum. The bedding material shall extend the full width of the trench and to a depth of at least six inches below the bottom of the distribution line. The bedding material shall extend at least two inches above the top of the distribution line. The bedding materials shall be covered by straw, newspaper, or untreated building paper or other pervious and/or biodegradable material to support the backfill as the laying of the distribution line proceeds. Tar paper, plastic, or other impervious material shall not be used between the bedding material and the earth backfill. Eight and ten inch gravel less seepage systems may be bedded with material excavated to construct the system. The gravel less seepage system requires no straw, newspaper or untreated building paper except as provided in Section 905.60(f).~~

~~f) Distribution lines. Distribution lines shall be constructed of materials as approved in Section 905.20(f). The lines shall be perforated or open joint tile. Where open joint tile is used, the tile sections shall be spaced not less than 1/4 inch nor more than 1/2 inch apart. Perforated piping (with the exception of 8" or 10" gravel less seepage beds) shall have 1/2 3/4 inch diameter openings on three to five inch centers with a minimum of two rows. The ends of the lines shall be looped except in serial distribution systems. In addition to Section 905.20(f), eight or ten inch gravel less seepage beds must comply with the following specifications:~~

~~1) The eight and ten inch I.D. corrugated polyethylene tubing shall meet the requirements of ASTM F667 84 Standard Specification for Large Diameter Corrugated Polyethylene Tubing with the following exceptions:~~

~~A) Perforations shall be uniformly spaced along the length of the tubing as follows: two (2) rows of holes 3/8 inch diameter for 8" tubing and 1/2 inch diameter for 10" tubing, located 120 degrees apart along the bottom half of the tubing, each 60 degrees up from the bottom centerline. These perforations shall be staggered so that there is only one hole in each corrugation.~~

~~B) The pipe or wrap shall be marked to indicate the top of the pipe.~~

~~2) All gravel less drainfield pipe shall be encased at the point of manufacture with a spun bonded nylon filter wrap having the following characteristics:~~

Physical Properties	Minimum Value

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Grab Strength, lbs. (ASTM D1682-64 -Reapproved 1975)	
Machine Direction	19
Transverse Direction	11
Burst Strength, psi. (ASTM D3786-80a)	26
Air Permeability, cfm per sq. ft. (ASTM D737-75, Reapproved 1980)	500

Particle Size Distribution (ASTM P-662-80)
Polyethylene particles in water and alcohol solution coulter counter analysis, single pass

Particle Size (Microns)	% Retained
70	80
60	68
50	56
40	40
30	22
20	5

3) Eight or ten inch gravel less seepage beds shall comply with all requirements which apply to standard gravel trench systems as stated in Appendix A unless otherwise stated in the Code.

g) Serial Distribution. Serial distribution shall be used in areas where the slope of the terrain prohibits the installation of conventional subsurface seepage systems. The following criteria shall be used in the design and construction of a serial distribution system: (Appendix A: Illustration K)
1) The bottom of each trench and its distribution line shall be level.
2) There shall be a minimum of 12 inches of earth backfill over the bedding material in the trenches.
3) The trench shall follow the ground surface contours so that variation in trench depth will be minimized.
4) There shall be a minimum of six feet of undisturbed earth between the septic tank and the nearest trench.
5) Adjacent trenches shall be connected with a relief line or a drop box arranged so that each trench is completely filled to the full depth of the gravel or gravel less pipe before effluent flows to the succeeding trench.
6) The relief lines connecting the trenches shall have watertight joints and direct connections to the distribution lines in adjacent trenches. Tight joint "T's" and 45o wells, or a drop box arrangement shall be used to connect adjacent trenches.

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7) Where the relief pipe trench connects with the higher trench, it shall not be deeper than the top of the gravel or gravel less pipe in the higher trench. Relief lines shall rest on undisturbed earth and the backfill shall be carefully tamped.
8) The invert of the first relief line shall be at least six inches lower than the invert of the septic tank or aerobic treatment plant outlet. (See Appendix A: Illustration K)
9) All other construction features of the serial distribution field shall comply with Subsections (a) through (g) of this Section.

h) Seepage Beds. The total bottom area of the seepage bed shall be one and one half times the area specified in Appendix A. Illustration H. Construction features shall conform to Subsections (a) through (f) of this Section. Distribution lines shall be spaced no farther than six feet center to center and shall be equally spaced. Lines adjacent to the bed sidewalls shall be three feet from the bed sidewall. (See Appendix A: Illustration B)

i) Seepage Pits. Seepage pits are approved for disposal of septic tank or aerobic treatment plant effluent, only where the following conditions exist:
1) The top four feet of soil is unsuitable for seepage fields or beds as determined by percolation tests. (Appendix A: Illustration G)
2) There is sufficient depth of permeable soil below the top four feet to adequately absorb the design flow.
3) There shall be no water wells within 100 feet of the proposed seepage pit.
4) Neither the seasonal high water table, nor fractured limestone are within 14 feet of the ground surface. Compliance with this requirement shall be determined by backhoe excavations or soil borings which are witnessed by the Department or local authority representative.

j) Construction Requirements. Where seepage pits are to be used, the design and construction shall conform to the following: (See Appendix A: Illustration M)
1) The maximum depth for any seepage pit is ten feet below the ground surface.
2) The required absorption area shall be determined from Appendix A, Illustration M. The percolation rate shall be the weighted average of the percolation rates of each soil layer penetrated. The weighted average shall be based on the proportionate depth of each soil layer penetrated. (See Appendix A: Illustration H, Notes 2 and 4)
3) The effective area of the seepage pit shall be the vertical wall area of the pervious strata below the inlet of the seepage pit.
4) Seepage pits walls shall be constructed of concrete block, brick, or perforated concrete ring. Mortar shall be used in the horizontal joints only. A minimum 12 inches space shall be provided between the pit walls and the excavation and this space

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~~shall be filled with clean coarse gravel.~~

~~5) The bottom one foot of the pit shall be filled with clean coarse gravel.~~

~~6) A four inch thick, reinforced concrete cover with a 24 inch diameter covered access opening shall be provided over the pit. Access to the pit shall not be deeper than six inches below the ground surface.~~

~~7) If multiple pits are used, they shall be installed in series and shall be separated by a minimum distance equal to three times the diameter of the largest pit.~~

a) Seepage Field Requirements - Gravel and Gravelless. Subsurface seepage fields shall be designed and constructed in accordance with Appendix A: Illustrations H, I, and J of this Part and the following:

1) All subsurface seepage systems using soils information for sizing shall use the soil suitability table in Appendix A: Illustration M of this Part to determine the size requirements of the subsurface seepage system. The least permeable soil profile between the top of the gravel or gravelless pipe and the limiting layer shall be used to determine the size of the subsurface seepage system.

2) The bottom of the subsurface seepage field, each trench and its distribution line shall be level. Level for this Part shall mean plus or minus 1/2 inch in any direction over the entire area of the subsurface seepage system.

3) There shall be a minimum of 6 inches and a maximum of 24 inches of earth backfill over the bedding materials or gravelless pipe.

4) There shall be a minimum of 5 feet of undisturbed earth between the septic tank and the nearest trench.

5) If precipitation falls onto the excavation and evidence of soil washing into the excavation of the subsurface seepage system exists, that portion of the seepage system damaged shall be reconstructed to conform with this Section.

6) The top of the gravel or gravelless pipe in the subsurface seepage field shall be at least one inch below the invert of the outlet pipe from the septic tank or distribution box in a gravity flow system.

7) Site Evaluation for Subsurface Seepage Systems.

A) Subsurface seepage systems receiving septic tank effluent shall have at least 2 feet of vertical separation distance between the bottom of the subsurface seepage system and the top of the limiting layer. For soils in Design Group I-VI or with a loading rate of greater than .62 gallons per day per square foot, a vertical separation of 3 feet between the bottom of the subsurface seepage system and the top of the limiting layer is required.

B) If a percolation test is used to design the private sewage disposal system, the private sewage disposal system

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installation contractor or homeowner shall submit information with the plan approval application or local health authority permit application that a limiting layer does not exist within the distances provided in subsection (a)(7)(A) of this Section.

8) Sizing of a seepage system in fill soil.

A) The least permeable soil profile between the top of the gravel or gravelless pipe and the limiting layer shall be used to determine the size of the subsurface seepage system.

B) The use of fill for installing subsurface seepage systems shall not be approved for lots platted after the effective date of this Part.

C) Fill soils may be used to cover a private sewage disposal system provided no part of the system is located in the fill and the fill material is at least equal to or better than the original soil or meets the requirements in subsection (a)(9) of this Section.

9) Soil criteria for use of fill for subsurface seepage systems.

A) Soils to be utilized for fill shall be identified by a soil classifier or licensed professional engineer and a report submitted to the Department or local authority. The report shall contain specific information on the fill soil including location, depth, permeability, and texture. Soils that can be used as fill are those identified in Appendix A: Illustration M of this Part as 2A, 2K, 3A, 3B, 3C, 3K, 3L, 4B and 4K (Design Group II, III and IV).

B) In addition to the above requirements, fill soil shall not contain extraneous material such as tires, concrete, brick, reinforcing bar, demolition material, etc.

C) All of the following conditions shall be met for a subsurface seepage system to be installed in fill.

i) Satisfactory original soil shall be at least 3 feet above bedrock.

ii) A maximum of 2 feet of fill soil shall be used.

iii) Fill shall not be placed on original soil with a slope greater than 10%.

iv) The fill shall be placed at the site so that a minimum of compaction occurs and the fill shall be allowed to settle undisturbed for a period of at least 12 months.

v) After the fill has been settled, a percolation test shall be conducted in accordance with the procedure outlined in Appendix A: Illustration G of this Part and a percolation rate of not greater than 270 minutes/6 inch fall or less than 60 minutes/6 inch fall shall be achieved.

10) Site Preparation for use of fill soil.

A) Excess vegetation shall be cut and removed. The site shall be plowed with a mold board plow 7-8 inches deep with the

plowing done perpendicular to the slope. It shall not be done with the furrow running up and down the slope. Chisel plowing may be used in place of mold board. Roto-tilling is prohibited.

B) Once the site is plowed, all traffic must be kept off the site. The fill material can be deposited on the top with a backhoe or pushed on from the side, preferably the upslope side, using a track type tractor, keeping 6 in. of fill beneath the tracks. At no time shall ruts be made in the plowed area. The fill shall be placed immediately after site preparation to avoid the possibility of precipitation falling on the plowed area.

C) Traffic on the downslope side of the fill area shall be minimal to reduce compaction. All work shall be performed from the ends and upslope side. Compaction of the natural soil downslope will reduce the lateral movement of the effluent.

D) The fill shall not be placed on frozen ground or when the soil is wet. Moisture content of the soil is very important when filling. Site preparation shall not take place when the soil is too wet. To check moisture content, take a soil sample from the plow layer (7-8 inches) and roll it between the palms of the hands. If it rolls into a ribbon, it is too wet to prepare. If it crumbles, site preparation can then proceed.

b) Gravel Seepage Field Requirements.

1) Bedding Material. The bedding material shall be clean gravel or clean stone which is free of mud, silt, or clay, with particle size ranging from 3/4 inch minimum to 4 inches maximum. The bedding material shall extend the full width of the trench and to a depth of at least 6 inches below the bottom of the distribution line. The bedding material shall extend at least 2 inches above the top of the distribution line.

2) Distribution Lines. Distribution lines shall be constructed of materials as approved in Section 905.20(f). The lines shall be perforated or open-joint tile. Where open joint tile is used, the tile sections shall be spaced not less than 1/4 inch nor more than 1/2 inch apart. Perforated piping with the exception of 8 inch or 10 inch gravelless seepage beds shall have 1/2-3/4 inch diameter openings on 3 to 5 inch centers with a minimum of 2 rows. The openings in the pipe shall be placed downward.

3) Separation Material. Bedding materials shall be covered by straw, newspaper, untreated building paper, geotextile fabric or other permeable or biodegradable material to support the backfill as the laying of the distribution line proceeds. Tar paper, plastic, or other impervious material shall not be used between the bedding material and the earth backfill.

4) The ends of a gravel seepage field shall be looped except in serial distribution systems.

c) Gravelless Seepage Field Requirements. In addition to Section 905.20(f), 8 or 10 inch gravelless seepage systems shall comply with the following specifications:

1) 8 and 10 inch I.D. corrugated polyethylene tubing shall meet the requirements of ASTM F667-84, Standard Specification for Large Diameter Corrugated Polyethylene Tubing with the following exceptions:

A) Perforations shall be uniformly spaced along the length of the tubing as follows: 2 rows of holes 3/8 inch in diameter for 8 inch tubing and 1/2 inch in diameter for 10 inch tubing, located 120 degrees to 140 degrees apart along the bottom half of the tubing, each row 60 degrees to 70 degrees up from the bottom center line. The perforations shall be staggered so that there is at least one hole in each corrugation.

B) The pipe shall be marked to indicate the top of the pipe.

2) All gravelless drainfield pipe shall be encased at the point of manufacture with a filter wrap having the following characteristics:

Physical Properties	Minimum Value
Grab Strength, lbs. (ASTM D1682-64 -Reapproved 1975 or ASTM D4632)	
Machine Direction	19
Transverse Direction	11
Burst strength, psi. (ASTM D3786-80a)	26
Air Permeability, cfm per sq. ft. (ASTM D737-75, Reapproved 1980)	500

Particle Size Distribution (ASTM F 662-80) Polyethylene particles in water and alcohol solution coulter counter analysis, single pass

Particle Size (Microns)	% Retained
70	80
60	68
50	56
40	40
30	22
20	5

3) 8 or 10 inch gravelless seepage trenches shall comply with all requirements which apply to standard gravel trench systems as stated in Appendix A unless otherwise stated in this Part.

4) Bedding Material. 8 and 10 inch gravelless seepage systems may

be bedded with material excavated to construct the system. The backfill material shall not contain large clods of earth, demolition material or other extraneous material.

5) Separation Material. No straw, newspaper or untreated building paper shall be placed between the gravelless system and the earth backfill.

6) Bending. 8 inch and 10 inch gravelless pipe shall not be bent around corners on a radius of less than 5 feet. If a sharper radius is required, a tee shall be used.

7) Gravelless seepage systems are not required to be looped. Gravelless seepage systems which are not looped shall be capped on the end.

d) Serial Distribution. Serial distribution shall be used in areas where the slope of the terrain prohibits the installation of conventional subsurface seepage systems. The following criteria shall be used in the design and construction of a serial distribution system: (Appendix A: Illustration K of this Part)

1) The bottom of each trench and its distribution line shall be level.

2) There shall be a minimum of 6 inches of earth backfill over the bedding material or the gravelless pipe in the trenches.

3) The trench shall follow the ground surface contours so that variation in trench depth will be minimized.

4) There shall be a minimum of 5 feet of undisturbed earth between the septic tank and the nearest trench.

5) Adjacent trenches shall be connected with a relief line or a drop box arranged so that each trench is completely filled to the full depth of the gravel or gravelless pipe before effluent flows to the succeeding trench.

6) The relief lines connecting the trenches shall have watertight joints and direct connections to the distribution lines in adjacent trenches. Tight joint "T's" and 45° ells, or a drop box arrangement shall be used to connect adjacent trenches.

7) Where the relief pipe trench connects with the higher trench, it shall not be deeper than the top of the gravel or gravelless pipe in the higher trench. Relief lines shall rest on undisturbed earth and the backfill shall be carefully tamped.

8) The invert of the first relief line shall be at least one inch lower than the invert of the septic tank or aerobic treatment plant outlet. (See Appendix A: Illustration K of this Part.)

9) All other construction features of the serial distribution field shall comply with subsections (a) through (d) of this Section.

e) Seepage Beds. The total bottom area of the seepage bed shall be one and one-half times the area specified in Appendix A: Illustration H of this Part. Construction features shall conform to subsections (a) and (b) of this Section. Distribution lines shall be spaced no further than 6 feet center to center and shall be equally spaced. Lines adjacent to the bed sidewalls shall be 18 inches from the bed

sidewall. (See Appendix A: Illustration L of this Part.) Seepage beds shall be constructed so that construction equipment does not drive over the bottom of the bed.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.70 Buried Sand ~~Filter~~ Filters

a) General. Buried sand ~~Sand~~ filters may be used, provided the effluent is discharged in accordance with the requirements of Section 905.110.

~~b) Buried Sand Filters.~~

~~1)~~b) Size. Buried sand filters shall be sized as follows: ~~The sand filter surface area for residential systems shall be 200 square feet per bedroom. For non-residential systems, the sand filter surface area shall be one square foot per gallon per day, and the minimum size for a buried sand filter shall be 100 square feet. Where a sand filter is used in conjunction with a aerobic treatment plant, the size of the sand filter may be reduced by 50 percent.~~

1) Residential. The sand filter surface area for residential property shall be 200 square feet per bedroom. Where a sand filter is used in conjunction with an approved aerobic treatment plant, the surface area of the sand filter may be reduced by 50 percent.

2) Non-Residential. All of the following shall be met when a buried sand filter is to be installed on non-residential property.

A) The surface area of the sand filter shall be designed for one square foot per gallon per day for waste with an influent Biochemical Oxygen Demand (BOD) not to exceed 300 parts per million (ppm).

B) A sand filter with flows of 801 gallons or more per day shall have the effluent distributed into the sand filter by a pressure dosing system designed according to subsection (1) of this Section.

C) The sand filter shall be dosed 4 times per day with equal flows not to exceed the design capacity of the filter.

c) A single individual sand filter shall be used to treat flows from a wastewater source. Splitting flows prior to treatment or the use of multiple sand filters shall be prohibited unless subsurface disposal of the effluent is used. Where allowed, splitting of flows shall be done by pumps.

d) Minimum Size. The minimum size buried sand filter shall be designed to treat at least 100 gallons of waste per day.

~~2)~~e) Sand Filter Media. The depth of filter media shall be a minimum of 24 inches. The sand shall have an effective size of 0.5 to 2.0 millimeters, and a uniformity coefficient of less than 3.5. It shall be clean and free of clay and silt.

~~3)~~f) Alternate Media. Other filter media may be used in a subsurface

filter provided it meets the criteria of ~~Subsection (f)~~ subsection (e) of this Section ~~above~~ and complies with the following requirements.

~~A)~~ 1) Is chemically and biologically inert.

~~B)~~ 2) Will support biological growth.

~~C)~~ 3) Has a hardness equivalent to, or greater than, that of sand.

~~4)~~ g) Filter Media Cover. The filter media shall be covered with a minimum of ~~ten~~ 10 inches of clean coarse gravel or clean stone which is free of mud, silt or clay, ranging in size from 3/4 to 2 1/2 inches in diameter. The gravel or stone shall be covered with straw, ~~or~~ untreated building paper, or other permeable material prior to backfilling. A minimum of 12 inches earth cover shall be provided. (See Appendix A: Illustration N of this Part.)

~~5)~~ h) Distribution and Collection Lines. The distribution and collection lines shall conform to the requirements for distribution lines as given in Section 905.60~~(f)~~(b)(2). The distribution lines shall be level, shall be located 18 inches ~~three feet~~ from sidewalls, and shall be spaced on ~~three~~ 3 foot centers. There ~~They~~ shall be solid pipe to the filter media. The collection lines shall have a slope of ~~six~~ 6 inches per 100 feet and one collection line shall be provided for each ~~ten~~ 10 feet of width or fraction thereof. The upper end of the collection line shall be capped.

~~6)~~ i) Bedding Material. The bedding material for the collection lines shall be placed as shown in Appendix A: Illustration N of this Part, shall be clean gravel or clean stone which is ~~be~~ free of mud, silt or clay. ~~and shall consist of clean gravel or stone.~~ The coarse gravel shall range in size from 3/4 to 2 1/2 inches in diameter and pea gravel shall range from 1/8 to 3/8 inches in diameter. A minimum of ~~two~~ 2 inches of coarse gravel shall be placed on the excavation before placement of the collection lines.

~~7)~~ j) Venting. A minimum of one vent shall be placed on the downstream end of the distribution lines as shown in Appendix A: Illustration N of this Part. These vents shall be placed as close as possible to the corners on the downstream distribution lines. The ~~vent~~ vents shall extend above the ground surface and be screened with 1/4 inch mesh screen or equivalent.

~~8)~~ k) ~~Drainge~~ Drainage. Surface drainage shall be directed away from the filter. If conditions prohibit gravity drainage of the filter effluent, a pumping chamber shall be installed. The chamber shall be constructed of a watertight, non-corrosive material and shall be provided with a removeable lid, which will serve as an access for inspection, cleaning, and general maintenance. An access port or extension collar shall extend at least 6 inches above ~~be brought to within 12 inches of~~ the ground surface, and the access shall have a minimum dimension of 12 inches. The chamber shall have sufficient depth and the pump controls shall be set in a manner to allow for complete drainage of the filter to eliminate any ponding of effluent within the filter. (See Section 905.125 Pumps, Pump Chambers and Ancillary Equipment.)

~~9)~~ ~~Adverse Site Conditions. In areas where the seasonal high ground water table rises to within six inches of the bottom of the filter, the filter shall be lined with an impermeable, non biodegradeable material, either natural or man made.~~

l) Distribution of Effluent. Buried sand filters designed to treat non-residential property with flows of 801 gallons or more per day shall have the effluent distributed into the sand filter by pumping. The pumps, pumping chamber and ancillary equipment shall comply with Section 905.125 and the following:

1) Dosing volume. Dosing shall not exceed 4 times a day. The dosing volume is the amount of liquid pumped or siphoned during each cycle minus the amount which drains back from the system after each dose.

2) Pump Selection. The pump shall be a submersible pump designed for corrosive liquids.

3) Siphons. Siphons can be designed where elevation exists between the sand filter and the siphon chamber. However, the siphon shall be designed to deliver the same flow rate at the same head at the distribution system as a pump system. The distribution system consisting of manifold and laterals shall be designed so that it will drain after each siphon. This shall be accomplished by placing the manifold above the laterals.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.80 Recirculating Sand Filter

a) General. The recirculating sand filter system (Appendix A: Illustration O of this Part) consists of a septic tank, recirculation tank, open sand filter, and flow splitter. It may be used provided the effluent is discharged in accordance with the requirements of Section 905.110.

b) Septic Tank. The septic tank shall be sized and installed as described in Section 905.40.

c) Recirculation Tank. The recirculation tank volume shall be 500 gallons and the tank shall be equivalent in strength and materials to the septic tank as provided in Section 905.40. No baffles are necessary. An access manhole, as described in Section 905.40(b)(7)~~(g)(3)~~, shall be provided for pump maintenance or replacement.

d) Sand Filter. The sand filter shall be sized at one square foot of filter surface for every ~~three~~ 3 gallons per day of domestic sewage flow. Appendix A: Illustration P of this Part has a size chart for residences based on numbers of bedrooms. Unless otherwise stated in Appendix A: Illustration P of this Part the sizes shown are required. The filter media shall comply with requirements of Section 905.70(e)~~(b)(2)~~ and (f)~~(3)~~ and shall be 30 inches in depth.

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e) Bedding Material. The bedding material for the collection lines shall be the same as that in a buried sand filter. The coarse gravel shall be 3/4 to 2 1/2 inch diameter and the pea gravel shall be from 1/8 to 3/8 inches diameter. A minimum of ~~two~~ 2 inches of coarse gravel shall be placed on the excavation prior to placement of collection lines.

f) Distribution and Collection Lines. The collection lines shall be constructed of materials as approved in Section 905.20(f) and shall be ~~four~~ 4 inches inside diameter perforated piping laid with perforations facing downward. The distribution piping shall have an inside diameter of 1 1/2 inches. The perforated pipe shall have 1/2 to 3/4 inches diameter openings on 3 to 5 inch centers with ~~two~~ 2 rows at 120° from each other. Distribution piping shall be spaced on ~~three~~ 3 foot centers and shall be located a minimum of 1 1/2 feet from sidewalls.

g) Pumps. The pump shall be a submersible pump designed for corrosive liquids and shall have a capacity of 15 to 25 gallons per minute at the ~~ten~~ 10 foot total dynamic head (TDH). The pump shall be controlled by a time clock which can be set to activate the pump at one hour or longer intervals. Pump shut-off shall be controlled by a low level float switch which allows the entire contents of the recirculation tank to be pumped during each pump cycle. A high level float switch shall be provided that energizes a visible and audible alarm to indicate pump failure or malfunction. (See Appendix A: Illustration Q of this Part.)

h) Flow Splitter. The flow splitter shall be designed so that recirculation rates can be controlled between no recirculation and a 5 to 1 recirculation ratio. An example of one type of splitter is shown in Appendix A: Illustration O of this Part.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.90 Waste Stabilization Ponds

General. Waste stabilization ponds may be used if designed and constructed in accordance with the following criteria and provided the effluent is discharged in accordance with the requirements of Section 905.110 (See Appendix A: Illustration R of this Part as an illustration of these requirements). A septic tank sized according to 905.Appendix A: Illustration F of this Part or an aerobic treatment plant shall precede a waste stabilization pond.

a) Location: A waste stabilization pond shall be located as distant as practical from residences, but in no case closer than the distances shown in Appendix A~~;~~: Illustration D of this Part, and in an area where trees will not interfere with sunlight on the surface.

b) Dimensions. Ponds shall have a length not exceeding ~~three~~ 3 times the width.

c) Capacity. When domestic sewage from a septic tank is to be discharged to the waste stabilization pond~~;--the-capacity-shall-be-equivalent-to~~

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~~90-times-the-average-daily-flow;--When-preceded-by-a-septic-tank~~, the capacity of the pond shall be equivalent to 60 times the average daily flow. When preceded by ~~an~~ a Class II aerobic treatment plant, the capacity of the pond shall be equivalent to 18 times the average daily flow.

d) Depth. The wastewater depth for a waste stabilization pond shall be uniform and ~~three~~ 3 feet to ~~five~~ 5 feet.

e) Freeboard. A minimum freeboard of ~~two~~ 2 feet shall be provided.

f) Embankments. Embankments shall be constructed ~~or~~ of impermeable materials and shall be compacted. Embankment slopes shall be in 1 to 2 (vertical to horizontal) below the water line and 1 to 3 or flatter above the water line. ~~Embankment--slopes--shall--be--one--to--three;--vertical--to--horizontal.~~ The top width of the embankment shall be a minimum of ~~two~~ 2 feet. Embankments shall be seeded or rip-rapped from the outside toe to the high water line. Perennial, low growing, spreading grasses that withstand erosion and can be kept mowed are most satisfactory for seeding of embankments.

g) Inlet. ~~Inlet-lines-in-excess-of-50-feet-in--length--which--carry--raw sewage;--shall--be-provided-with-a-clean-out;~~ The inlet line shall be placed 12 to 24 inches above ~~near~~ the bottom of the pond at a point opposite the overflow structure and shall be supported at no greater than ~~ten-feet~~ 10 foot intervals along its length. It shall discharge at least ~~ten~~ 10 feet from the water's edge. The inlet line shall be sloped in accordance with Section 905.20(g).

h) Outlet. The outlet structure shall be designed to prevent the discharge of floating solids. This ~~may~~ shall be accomplished through baffling. The baffle shall consist of a sanitary T or 90° elbow. If the 90° elbow is used, a 1/4 inch hole shall be drilled into the top of the elbow to provide an air break. The outlet baffle shall extend 12 inches below the invert of the overflow. The outlet baffle shall be 3 to 5 feet from the embankment. ~~or-other-means;~~

i) Bottom. The bottom of the waste stabilization pond shall be cleared and leveled to the required elevation and shall be lined with an impermeable natural or man-made material. The pond shall be kept free of vegetation which would grow to or above the water surface.

j) Drainage. All surface water shall be diverted away from the waste stabilization pond.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.100 Aerobic Treatment Plants

a) General. ~~After-the-effective--date--of--this--Code;--aerobic~~ Aerobic treatment plants shall be listed by NSF International as complying ~~comply~~ with the requirements of ANSI/NSF ~~the--National--Sanitation Foundation--(NSF)~~ Standard Number 40, Individual Aerobic Wastewater Treatment, July 1990. ~~May-1983;-and-shall-bear-the-NSF-seal.---Aerobic~~

~~treatment--plants--approved--by-this-Department-prior-to-the-effective date-of-this-Code-shall-continue-to-be-approved-as--indicated--in--the provisions--of-the-original-approval-issued-by-the-Department.--A-list of-approved-aerobic-treatment-plants-will-be-periodically-updated--and a--copy--of-this-list-may-be-obtained-from-the-Department.~~ Standard 40 is a standard which covers plants for treatment of wastewater from individual homes. This Part shall allow NSF approved aerobic treatment plants to serve residential property which is occupied on a year-round or full-time basis. Aerobic treatment plants shall not be used to serve residential property which is used as a seasonal, weekend or part-time residence.

b) Class II Effluent. Aerobic treatment plants listed by NSF for Class II effluent (BOD5-60mg/l and Suspended Solids 100 mg/l) shall discharge to one of the following:

1) A subsurface seepage system designed and constructed in accordance with the requirements of Section 905.60.

2) A sand filter designed and constructed in accordance with the requirements of Sections 905.70 or 905.80.

3) A waste stabilization pond designed and constructed in accordance with the requirements of Section 905.90.

c) Class I Effluent. Aerobic treatment plants listed by NSF for Class I effluent (BOD5-30 mg/l and Suspended Solids 30 mg/l) shall discharge to one of the following:

1) A subsurface seepage field designed and constructed to be at least 2/3 the size determined necessary by Section 905.60. ~~percolation-tests.~~

2) To a surface discharge ~~To-the-ground-surface~~ in accordance with Section 905.110.

d) Sizing. Aerobic treatment plants which are listed by ~~N.S.F.~~ NSF as Class I and rated at 500 gallons per day will be allowed for the treatment of sewage from residential property ~~homes~~ having up to and including 4 ~~four~~ bedrooms. Other aerobic treatment plants which are listed by NSF as Class I shall be sized as follows:

Bedrooms	Minimum Rated Treatment Capacity-Gallons
1	400
2	400
3	500
4	500
5	750
6	900
7	1000
8	1200
9	1350
10	1500

e) Installation. All components of aerobic treatment plants shall be

installed at the time of the original installation. If this is not possible, a solid end cap shall be securely placed over the end of the discharge line until the system can be completed. This will prevent the discharge of raw sewage to the ground surface.

f) Accessibility for inspection and maintenance: The plant shall be equipped with one or more grade-level access manholes located to permit periodic physical inspection and maintenance of all compartments and component parts. Component parts include submerged bearings, moving parts, tubes, intakes, slots, filters, and other devices. Grade level access manholes shall be installed in a manner to prohibit the entry of soil, water and dirt into the unit. ~~Access. Aerobic-treatment-plants-shall-be-accessible-to-allow-maintenance--and service-of-all-components-within-the-plant.~~

g) Service. Devices falling within the scope of Standard 40 require periodic maintenance to achieve performance consistent with demonstrated capabilities. Implicit in Standard 40 is the recognition that assured professional service is imperative. Standard 40 and this Part require a 2-year service policy to be provided as part of the initial service agreement. (Note: The following initial service policy includes items not included in the NSF Standard 40 service policy.)

1) Initial service policy: A 2-year policy shall be furnished to the purchaser by the private sewage disposal installation contractor through the manufacturer or the distributor of the aerobic treatment unit. This policy shall provide:

A) Four inspection/service calls, at least one every 6 months, which includes inspection, adjustment, and servicing of the mechanical and the applicable component parts to ensure proper function;

B) For an effluent quality inspection consisting of a visual check for color, turbidity, scum overflow, and an examination for odors;

C) For improper operation which cannot be corrected at that time, to be reported to the owner immediately. This shall be followed with a written report which includes the date for the condition to be corrected.

2) Continuing service policy: Each manufacturer shall make available for purchase by the owner a continuing service policy with terms equal to the initial service policy.

3) Standby parts: Standby mechanical and electrical component parts shall be stocked by the local distributor for use when the plant's mechanical or electrical components must be removed from the site for repairs.

4) Component parts: The mechanical and electrical component parts shall be guaranteed against any defects in materials and workmanship as warranted.

5) Service: Service shall be available within 2 working days following a request.

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6) Owner's manual: An owner's manual shall be provided by the manufacturer with each unit. The manual shall include the following information:
   A) Model numbers.
   B) Functional description of unit including a statement of minimum performance requirements as established by test.
   C) Design and flow diagrams.
   D) Warranty.
   E) Replacement policy and service policy.
   F) Installation instructions.
   G) Detailed operation and maintenance requirements (including user responsibility, parts and service).
   H) Rated service flow in gpm (gallons per minute) or gpd (gallons per day).
   I) Energy source and energy required for proper operation of the plant.
   J) Specification of models tested under ANSI/NSF Standard 40.
7) Service label: A clearly visible, permanently attached label or plate giving instructions for obtaining service shall be placed at the audible and visual alarm.
8) Responsibility of property owner: The property owner shall be responsible for maintaining and operating the plant in accordance with this Part and the manufacturer's specifications.

h) Operation. Aerobic treatment plants shall produce an effluent meeting the physical, chemical and biological requirements of Section 905.110. Under normal operation and in the event of an electrical or mechanical failure or other performance failure or malfunction, the design and construction of the aerobic treatment plant shall prevent the discharge of wastewater from any opening which is not part of the designed flow path of the entire treatment process and shall prevent the discharge of wastewater which is not in compliance with Section 905.110.

i) Maintenance. In the event that a routine service call indicates an electrical, mechanical or performance failure or malfunction or if routine laboratory test results indicate improper treatment, the property owner shall immediately take action to bring the aerobic treatment plant into compliance with this Part.

j) Non-residential use. Aerobic treatment plants which are listed by NSF as Class I will be considered for use to serve a non-residential property provided all of the following are met:
   1) Total daily flows from the wastewater source into the plant are at least 75% of the rated hydraulic capacity and do not exceed the rated hydraulic capacity of the plant.
   2) Wastewater effluent shall not exceed the manufacturer's design specifications for BOD5 loading as established by NSF during testing of the plant.
   3) Hourly flows from the wastewater source into the plant are less than or equal to the treatment capacity of the plant divided by 24. This may require the installation of a flow equalization device.
   4) A buried sand filter sized with a surface area equal to 2 gallons per square foot per day and dosed at least once but not more than 4 times per day shall immediately follow the aerobic treatment plant.

k) Any wastewater source shall be served by a single individual aerobic treatment plant. Splitting of flows from a wastewater source or the use of multiple aerobic treatment plants shall be prohibited unless subsurface disposal of the effluent is used. Where allowed, splitting of flows shall be done by pumps.

l) Private sewage disposal installation contractors or homeowners who maintain or service aerobic treatment plants shall be required to maintain the integrity of the NSF seal. Only component parts approved for use in an individual plant may be used. No design changes or component part changes may be made which will void the NSF seal. Any person who voids the NSF seal shall be responsible for repairing the plant so it can bear the NSF seal or shall replace the plant with an approved private sewage disposal system.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.110 Effluent Surface Discharges

a) General. Buried sand filters, recirculating sand filters, ~~lagoons~~ waste stabilization ponds, and aerobic treatment plants listed by NSF for Class I effluent (See Section 905.100(a) and (c)) may be discharged to one of the following:
   1) A receiving stream, river, lake, or pond which provides greater than a 5 to 1 ~~one-to-one~~ dilution of the effluent. A discharge within 10 feet of the above shall be considered to be a discharge to the receiving body of water. Discharges to a lake or pond shall be limited to 2 discharges per surface acre of water. More than 2 discharges may occur per individual surface acre of water, however, the total number of discharges to total surface acres of water shall not exceed a ratio of 2 to 1. An example of this is as follows: In a 20 acre lake, several discharges may enter the lake in a 1/2 acre cove; however, the total discharges entering the lake would be limited to 40. Where discharges are not equally distributed around a lake or pond the Department or local authority shall be consulted to assure that nuisance conditions are not created.
   2) A ~~To--a~~ common collector ~~drain~~ provided that the collector ~~drain~~ does not discharge within one mile upstream from a public water supply intake, public bathing beach, or to any public use area. A public use area is any area which is frequently used by the public. Examples of a public use area are playgrounds and picnic

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areas. Common collectors used to carry treated effluent for 2 or more discharging systems with a combined design flow of less than 1500 gallons per day shall be constructed of materials as listed in Appendix A: Illustration C of this Part, and shall discharge in accordance with subsections (a)(1) and (3) of this Section. Whenever effluent discharges are combined into a common collector and the combined flow is less than 1500 gallons per day all the following shall be met:

A) The owner of the property shall be responsible for obtaining written permission from the owner or owners of the common collector to discharge effluent from the private sewage disposal system into the common collector. A copy of this written permission shall be submitted to the Department or local authority.

B) The owner of the property shall be responsible for determining how many discharging private sewage disposal systems are connected to the common collector and shall guarantee that the additional discharge from the property combined with the current discharges into the common collector shall not exceed 1500 gallons per day. The Department or local authority shall verify this information prior to issuing a plan approval.

C) If the flow from any number of discharging systems is combined and exceeds 1500 gallons per day, then the owner of the property shall provide a copy of the construction permit obtained in accordance with 35 Ill. Adm. Code 309.202(a) and (b) and a National Pollutant Discharge Elimination System (NPDES) permit issued by the Illinois Environmental Protection Agency to the Department or local authority to demonstrate that the effluent from this private sewage disposal system can discharge to this location.

3) The ~~To the~~ ground surface, ~~in areas~~ where ~~the density of private~~ the discharge points of private sewage disposal systems with surface discharges does not exceed one per acre and the effluent does not pond or create a nuisance condition.

b) Whenever property is subdivided which does not provide private sewage disposal systems in compliance with Section 905.60 or Section 905.110(a) then a sewage system in compliance with 35 Ill. Adm. Code 301 shall be provided.

c) If the final discharge location of the effluent from a buried sand filter, recirculating sand filter, waste stabilization pond or aerobic treatment plant listed as Class I by NSF will discharge according to this Section and leave the property, then an effluent receiving trench or bed shall be installed prior to discharge. Effluent receiving trenches or beds shall be designed in accordance with Section 905.60(a) through (e) except for the following criteria:

1) The effluent receiving trench shall be designed at 3 gallons per square foot of trench bottom area based on the daily design flow

of the system. An example of this is as follows: A 3 bedroom home equals 600 gallons per day. 600 gallons per day divided by 3 gallons per square foot per day equals 200 square feet of effluent receiving trench (600 gpd divided by 3 gallon/sq ft/day = 200 square feet).

2) Effluent receiving trenches or beds shall not be greater than 36 inches below the ground surface and shall have a minimum earth cover of 6 inches and a maximum earth cover of 12 inches.

3) They shall be designed so the entire trench or bed is completely filled with effluent prior to discharge and the invert of the overflow line is at least one inch below the invert of the outlet of the aerobic treatment plant, sand filter or waste stabilization pond unless the effluent is pumped.

4) They shall be designed so effluent enters the effluent receiving trench and fills it, but excess effluent from the sand filter, lagoon or aerobic treatment plant flows directly to discharge as shown in Appendix A: Illustration X of this Part.

~~b)~~d) Effluent Standards.

1) All surface discharges from private sewage disposal systems shall comply with United States Environmental Protection Agency Secondary Treatment Guidelines for BOD5 and Suspended Solids:

A) BOD5

i) ~~BOD5:~~--Arithmetic mean of all effluent samples collected in a period of 30 consecutive days; 30 mg/l (milligrams per liter) and 85 percent removal.

ii) Arithmetic mean of all effluent samples collected in a period of 7 consecutive days; 45 mg/l.

B) Suspended Solids:

i) Arithmetic mean of all effluent samples collected in a period of 30 consecutive days; 30 mg/l and 85 percent removal.

ii) Arithmetic mean of all effluent samples collected in a period of 7 consecutive days; 45 mg/l.

C) No effluent shall contain settleable solids.

D) Color, odor, and turbidity must be reduced to below discernable levels.

E) No effluent shall contain floating debris, visible oil, grease, scum, or sludge solids.

F) A fecal coliform bacteria concentration not exceeding 400 organisms per 100 ml (milliliter) except where chlorination is not required.

2) Samples shall be analyzed in accordance with the ~~1978 edition of~~ "Standard Methods for the Examination of Water and Wastewater" ~~as published by American Public Health Association~~.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 905.120 Disinfection

a) General. Surface discharges shall be disinfected with a chlorine solution under the following conditions:

1) When the effluent is discharged to or from an effluent receiving trench or bed and the effluent leaves the property.

~~1~~2) When an individual effluent or the effluent from a common collector ~~drain tile~~ is discharged to a pond, lake, or stream in which swimming, water skiing, or other water contact recreation occurs.

~~2) When an effluent is discharged to the ground surface in accordance with Section 905.110(a)(3), it shall be disinfected if it leaves the property or discharges to an area where ponding of the effluent is likely to occur.~~

b) Chlorine Feeders. Chlorination equipment shall have a means of removal of solids. Appendix A: Illustration S of this Part provides an example of a typical chlorine feeder. All chlorine feeders shall meet the requirements of ~~Appendix S~~ Appendix A: Illustration S of this Part. Other feeders which meet the requirement of this Section are also acceptable.

c) Chlorine Contact Tanks. Chlorine contact tanks shall be baffled and shall provide a contact time of at least 30 minutes based on ~~two and one half~~ 2 1/2 times the average flow. The minimum contact tank capacity shall be 30 gallons. Access to the distribution feeder shall extend to the ground surface.

d) Sample Port. A sampling port at least ~~four~~ 4 inches in diameter shall be provided on the effluent line or into the chlorine contact tank, unless a free-fall discharge from the system is easily accessible within 200 feet of the system.

e) Chlorine Residual. A final effluent free chlorine residual of 0.2 to 1.5 mg/l shall be maintained.

f) Chlorine products used for the disinfection of treated wastewater effluent shall be used according to the product's labeling.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.125 Pumps, Pumping/Dosing Chambers, Ancillary Equipment

a) Pumps shall meet the following requirements:

1) The pump shall be submersible.

2) The pump shall be designed to handle wastewater and a minimum of 1/2 inch diameter solids.

3) The pump shall be capable of delivering the required flow at the design total dynamic head. The discharge pipe shall be the same size or larger than the discharge of the pump.

4) The pump shall be constructed of corrosion resistant materials.

5) Performance curves and specification sheets indicating the above

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criteria have been met shall be submitted with the plan review application when pumps are to be used in a system.

b) Pump Chambers

1) Pumping Chamber. The pumping chamber shall be watertight. Watertight shall consist of sealing all joints. The pumping chamber shall be filled with water after being installed and backfilled to prevent the pumping chamber from floating out of position due to hydrostatic pressures, unless the tank is installed in dry soil.

A) The volume of the pumping chamber shall be sufficient to provide the desired dosing volume, space for controls, space for setting the pump, reserve capacity malfunction and flow-back after the pump shuts off (volume of manifold and laterals).

B) A reserve capacity above the active pumping volume equal to one-half day's design flow shall be provided if single pumps are used. A reserve volume is not needed if siphons or dual pumps are used.

C) An access riser shall extend at least 6 in. above the ground surface.

2) Dosing volume. The dosing volume shall be at least 5 times the pipe volume of the dosing network plus provide for filling and drainback of the network. The average flow shall be used to determine the dosing volume.

3) Pump and Alarm Control. The pump control device shall be adjustable so that the required dosing volume is discharged during each pumping cycle. The control system for the pumping chamber shall consist of a control for operating the pump and an alarm system to detect when the system is malfunctioning. Pump controls shall allow flexibility in adjusting the on-off depth. An example of acceptable controls are shown in Appendix A: Illustration O of this Part.

4) Electrical and Alarm System. A high water alarm shall be provided with audible and visual signals and a test function. The alarm shall be on a separate circuit and located in the home or facility served. The alarm control device shall be a sealed float or diaphragm switch and shall be located to activate 2 - 3 inches above the pump turn-on level or siphon activation level.

c) Ancillary Equipment

1) A quick disconnect device shall be included in the discharge piping to facilitate removal of the pump for inspection, repair, or replacement. The disconnect device shall be a threaded union, pitless adapter, or lift-out rail system.

2) A corrosion resistant rope or cable of adequate strength shall be affixed to the pump to facilitate installation and removal and so that personnel need not enter the chamber to disconnect the pump.

3) A pump control device must be adjustable so that the desired dosing volume can be discharged during each pumping cycle. The

control device may consist of one or more sealed float or diaphragm switches which may cooperate with a relay or contractor. Separate control panels located outside the chamber must be protected from the weather, and must provide no air path between the panel and the pump chamber.

4) A check valve between the pump and the piping network shall not be allowed unless this piping system is below the frost line.

(Source: Added at 19 Ill. Reg. _____, effective _____)

Section 905.130 Human Waste Disposal

a) General. Privies, portable toilets ~~chemical--toilets~~, recirculation toilets, incinerator toilets, and compost toilets are approved for private sewage disposal of human wastes. Others domestic wastes shall be disposed of in a conventional system, (Section 905.30) however, the size of all components may be reduced 25 percent (except that septic tanks may not be smaller than 750 gallons). Note: Compost toilets may be used to dispose of other organic domestic wastes.

b) Privy Construction. All privies shall be constructed and maintained in accordance with the following and Appendix A: Illustration T of this Part:

1) Pit Construction. The pit shall be constructed of materials and in such a manner as to be able to endure the anticipated load and use and to withstand the local environmental conditions without deteriorating. The pit shall be constructed such that there shall be access to the pit for pumping and cleaning purposes.

2) Pit Size. The pit shall have a minimum capacity of 50 cubic feet per seat.

3) Floor and Seat Riser. The floor and seat riser shall be constructed of an impervious material and in a manner to exclude insects and rodents. The seat riser shall be bonded to the floor to prevent seepage through the riser onto the floor.

4) Seat Cover. The seat opening shall be covered with a hinged lid which forms a tight seal.

5) Vent. Each pit or vault privy shall be provided with a vent to the outside which creates airflow out of the building through the vent. The vent opening shall be screened with 16 mesh screen to prevent the entry ~~to~~ of flies and shall terminate through the roof.

6) Maintenance and Abandonment. When any privy is abandoned or filled to within 18 inches of the bottom of the riser, it shall be pumped by a private sewage disposal system pumping contractor. Any abandoned privy pit shall be filled with earth.

c) Vault Privy. Watertight, non-metal vaults are required where privies are used in areas where the groundwater or limestone formations are within ~~four~~ 4 feet of the bottom of the pit. The vault shall be

provided with a readily accessible cleanout which prohibits the entry of rodents, insects, and surface water. (See Appendix A: Illustration T~~)~~ of this Part.)

d) Septic Privy. The vault of a septic privy shall be watertight. The subsurface seepage field shall consist of a minimum of one 10 foot distribution line placed in a ~~two~~ 2 foot wide trench constructed in accordance with Section 905.60 and Appendix A: Illustration U of this Part.

e) Standards for the Construction and Servicing of Non-Sewered (portable) Toilet Systems. A portable toilet is a self-contained unit equipped with a waste receiving holding container. Non-sewered toilet systems shall be constructed and maintained in the following manner:

1) Rooms, buildings or shelters housing toilets shall be of solid construction, easy to clean, providing shelter and privacy. The toilet room shall be ventilated to the outside, with the vent covered with 16 mesh screen. Internal latches shall be provided to prevent inadvertent entry.

2) Waste containers shall be fabricated from impervious materials such as plastic, steel, fiberglass or their equivalents. Containers shall be watertight and capable of containing the waste. Containers shall be adequate in size to be used by the number of persons anticipated without filling the container to more than half of its volume before regularly scheduled service.

3) Servicing shall include removing waste from containers, recharging containers with an odor controlling solution, installing a supply of toilet tissue based on its intended use, and cleaning urinals and seats. Employers and event sponsors are responsible for contracting service intervals frequent enough to ensure clean, sanitary facilities.

4) Any defective or inadequate toilet unit shall be repaired or withdrawn from service by locking or removal.

5) Removal of waste shall be handled in a sanitary manner by means of a vacuum hose and discharge to a leak-proof tank truck. All ports on the tank shall be valved and capped.

6) Service trucks shall have access to the toilets to be serviced.

7) Disposal of waste from tank trucks shall be in accordance with Section 905.170(g).

~~e) Chemical-Toilets.--Where-chemical--toilets--are--used,--the--owner--or private--sewage-disposal-contractor-shall-maintain-them-and-dispose-of their-contents-in-accordance-with-Section-905.170.~~

f) Recirculating Toilets.

1) Self-contained toilets which treat and recirculate the flushing liquid shall be constructed of an impervious, easily cleanable material and vented to the outside air through a screened pipe. The effluent, if any, from the recirculating toilet shall discharge into a subsurface seepage field or into a disposal bag. The subsurface seepage field shall consist of a minimum of one ~~ten~~ 10-foot long distribution line placed in a ~~two~~ 2-foot wide

trench constructed in accordance with Section 905.60. The owner of a recirculating toilet shall dispose of any residual from the unit in an approved public or private sewage disposal system.

2) Recirculating toilets shall comply with the requirements of the National Sanitation Foundation (N~S~F~) Standard 41 and shall bear the N~S~F~ seal.

g) Incinerator Toilets.

1) Incinerator toilets shall be designed and operated to provide complete incineration of the contents without production of odors. The owner of an incinerator toilet shall maintain the toilet and dispose of the contents in accordance with Section 905.170(e).

2) Incinerator toilets shall comply with the requirements of the National Sanitation Foundation (N~S~F~) Standard 41 and shall bear the N~S~F~ seal.

h) Compost Toilets.

1) Compost toilets shall be designed in accordance with the manufacturer's recommendations to serve the anticipated number of persons. The owner of a compost toilet shall maintain the toilet and dispose of the contents in accordance with Section ~~905.140~~ 905.170.

2) Compost toilets shall comply with the requirements of the National Sanitation Foundation (N~S~F~) Standard 41 and shall bear the N~S~F~ Seal.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.140 Holding Tanks

a) General. Holding tanks are approved for private sewage disposal only under the following circumstances:

1) To serve a seasonal use, single family residence, such as a cabin used only on weekends, short vacations, and other similar situations.

2) As a temporary measure while awaiting the availability of a municipal sewer extension. This temporary condition shall not exceed 1 year in length.

3) As a sanitary dumping station to receive the discharge from holding facilities on recreational vehicles.

4) To receive the discharge from fixtures or drains which receive waste products such as automotive grease, oils, solvents and chemicals which are not allowed to discharge into a private sewage disposal system. These waste products shall be handled according to Outline of Waste Disposal Regulations (35 Ill. Adm. Code 700). (Note: Also see Illinois Plumbing Code (77 Ill. Adm. Code 890).)

b) Approval. Approval for holding tanks shall be obtained in writing

from the Department or local authority prior to installation. Such approval shall be based on compliance with this Section.

c) Construction and Location. Holding tanks shall be designed and constructed in compliance with Section 905.40, "Septic Tanks", except that the outlet shall be permanently sealed. Holding tanks shall be located to comply with the requirements for "Septic Tanks or Aerobic Treatment Plants" as listed in Appendix A: Illustration D of this Part.

d) Conversion to Conventional Private Sewage Disposal Systems. Holding tanks installed under ~~Subsection~~ subsection (a)(2) ~~above~~ of this Section shall be converted to a conventional private sewage disposal system if a municipal sewer has not been extended to serve the property within one year of the original installation.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.150 Sanitary Dump Stations

a) General. Sanitary dump stations which receive the discharge of holding tanks on recreational vehicles shall be designed and constructed in accordance with the ~~Rules for~~ Recreational ~~Areas~~ Area Code~ (77 Ill. Adm. Code 800) and the following: (Appendix A: Illustration V of this Part indicates mandatory construction requirements)

~~1) A sanitary dump station shall be separate from any other private sewage disposal system.~~

~~2)~~1) A sanitary dump station with a disposal system shall be designed on the basis of 20 gallons per day per unsewered recreational vehicle site.

~~3)~~2) A sanitary dump station with only holding capabilities shall be designed on the basis of 140 gallons per unsewered recreational vehicle site.

b) Construction and Location. The construction and location of a sanitary dump station with a disposal system shall comply in all respects with the applicable ~~Rules in this Code~~ Sections of this Part, depending on the type of system used. The location and construction of a sanitary dump station with only holding capabilities shall comply with the requirements of Section 905.140.

c) Ancillary Requirements. A sanitary dump station shall be provided with the following:

1) A concrete pad sloped at least one inch per ~~ten~~ 10 feet to a drain. This pad hall extend at least ~~two~~ 2 feet in every direction from the drain, and shall have at least a ~~two~~ 2 inch high curb around the outside perimeter of the pad as indicated in Appendix A: Illustration V of this Part.

2) A foot-operated, self-closing cap which forms a tight seal with the drain shall be provided.

3) The sewer line from the drain to the tank shall be at least ~~four~~ 4 inches in diameter and constructed of material approved under Section 905.20(f). It shall be installed to maintain at least a ~~ten~~ 10 foot horizontal separation between the water and sewer line, and the water line and the tank.

4) A water supply distribution tap for flushing the pad shall be provided. The water supply line to the tap shall be of materials, location, and construction in accordance with the Illinois ~~State~~ Plumbing Code (77 Ill. Adm. Code 890), and shall be provided with approved, properly installed back siphonage protection. No "stop and waste" valves will be allowed on this tap. This water tap shall be posted, "Not for Human Consumption. Use for Flushing and Cleaning Purposes Only."

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.160 Swimming Pool Wastewater

a) General. Wastewater generated from the operation of a swimming pool includes clear wastes, such as drainage from the pool proper, deck drainage, and perimeter overflow system drainage; and turbid wastes, such as filter wash and backwash water.

b) Approved Treatment and Disposal. Wastewater from swimming pools may not be discharged to a private sewage disposal system receiving domestic sewage. It shall be disposed of in the following manner:

1) Clear water wastes may be discharged directly to storm sewers, natural ~~drainage~~ drainage areas, ~~seepage pits,~~ or to the ground surface without additional treatment. Such drainage shall not result in nuisance conditions which create an offensive odor, or which produce a stagnant wet area, or which produce an environment for the breeding of insects. These discharges will require an NPDES Permit from IEPA if contaminants are added to the discharge which will cause any water quality violation.

2) Wash or backwash water from sand filters may be discharged to natural drainage areas, storm sewers, seepage pits, or to the ground surface. Diatomaceous earth filter wash or backwash water may be discharged to one of the above after treatment consisting of one of the following:

A) Passing the wastewater through a separation tank designed for removal of the diatomaceous earth and suspended solids.

B) Settling the wastewater in a tank which is capable of holding the volume of one backwash. One backwash is defined as the amount of water generated from the backwash of the filters for a period of ~~two~~ 2 minutes for diatomaceous earth filters, at the required backwash flow rate. The tank shall be dewatered after settling and prior to subsequent backwashes. Settled sludge shall be periodically removed to

prevent flushing of solids during backwashing. (See Appendix A: Illustration ~~W~~ of this Part.)

C) A separate private sewage disposal system designed and constructed in accordance with the applicable Sections ~~in~~ of this ~~Code~~ Part.

~~c) Seepage Pits. Where seepage pits are used for the final disposal of swimming pool wastewater, they shall be designed on the basis of the anticipated flow and the percolation rate, as determined by the procedure outlined in Appendix A. Illustration G. Seepage pit construction shall comply with the requirements of Sections 905.60(i) and (j).~~

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.170 Servicing, Cleaning, Transporting and Disposing of Wastes from Private Sewage Disposal Systems

a) General. The collection, storage, transportation, and disposal of all septage shall be handled in accordance with this Section and in accordance with 40 CFR 503-Standards for the Use or Disposal of Sewage Sludge.

b) Truck Identification. The name under which the business is conducted and the town of company origin and telephone number of the business ~~address of each contractor~~ shall be painted on each side of every pumper truck ~~operated by him~~. The ~~letters~~ company name shall be easily legible and the letters shall be at least ~~three~~ 8 inches high in contrasting colors.

c) Equipment Inspection. Equipment shall be subject to inspection and approval by a representative of the Department or local authority at any reasonable time; and, upon request, shall be available for inspection at a designated location.

d) Vehicle Construction and Equipment. Each vehicle used for collection and transportation of waste shall be equipped with a leakproof and tightly sealed tank for septage hauling. The interior and exterior sections of all portable containers, pumps, hoses, tools, or other implements which have been contaminated shall be rinsed clean after each use and the rinsings shall be disposed of such that no health hazard or nuisance results. Trucks and tanks shall comply with the following:

1) The vehicle shall be equipped with either a vacuum pump or other type of pump which is self-priming and will not allow any seepage from the diaphragm or other packing glands.

2) The discharge nozzle shall be located so that there is no flow or drip onto any portion of the truck.

3) The discharge ~~drainage~~ nozzle shall be capped when not in use.

~~e) Septage Disposal Site. Each licensed contractor engaged in septage disposal shall file with the Department, and each year amend, a~~

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~~statement describing the location and methods of disposal of septage. Methods of septage disposal approved by the Department are as follows:~~

e) Notification of Disposal Site. Annually, the private sewage disposal system pumping contractor shall:

1) Notify the Department and local authority of the sites utilized for disposal. Information to be reported shall be: county, township, range, and section; with a description to the nearest 1/4 section, name and address of the owner of the property; and purpose for which the disposal site is otherwise used such as pasture, grain crops, mowing crops, or timber.

2) Provide an annual estimate of the total gallons of septage disposed of at each site.

3) Describe the methods of disposal at each site.

f) Disposal methods. Methods of septage disposal approved by the Department are as follows:

1) Discharge to a Municipal Sanitary Sewer System. Discharge to a municipal sanitary sewer system is approved when the municipality has approval from the Illinois Environmental Protection Agency to receive septage from private sewage disposal systems; and the contractor has written approval from the municipality to discharge septage into the system.

2) Application to Agricultural Land. Septage may be applied to agricultural land provided the following criteria are met:

A) The depth to the ground water table or to fractured limestone formations is at least ~~four~~ 4 feet below the ground surface.

B) The septage is disposed of in the following manner:

i) It originates from private sewage disposal systems which treat only domestic sewage as that term is defined in Section 3 of the Private Sewage Disposal Licensing Act ~~Ill. Rev. Stat. 1981, ch. 111 1/2, par. 116.303~~ [225 ILCS 225/3];

ii) It is not applied to land which has been saturated by rainfall during the 24-hour period preceding the intended application time;

iii) It is not applied to land with water ponded upon it;

iv) It is not applied to land within ~~150~~ 200 feet of wells, homes, the rim of a sink hole, underground mine, cave, tunnel, ~~or~~ other water supplies, ponds~~,~~ or streams~~.~~;

v) It is not applied to land having greater than 5% slope;

vi) It is not applied to land that is intended to grow root vegetables, or other low growing fruits or vegetables which may be eaten raw~~.~~;

vii) It is applied at a rate which does not exceed 5,000 gallons of septage per acre per month~~.~~;

viii) It is applied from a vehicle moving at least one mile per hour (88 feet per minute);

~~viii)~~ix) Where it is determined by the Department or local authority that a nuisance condition (~~See~~see Section 905.160(b)(1)) exists, then the septage shall be incorporated into the soil.

3) Discharge to Sludge Lagoons or Sludge Drying Beds. Discharge to a sludge lagoon or drying bed must be approved by the Illinois Environmental Protection Agency, (IEPA) (35 Ill. Adm. Code 309) or the owner/operator of the lagoon or drying bed must have a permit from the IEPA to receive septage from the contractor. If the contractor is going to construct a sludge lagoon or drying bed, a permit will be necessary from the IEPA to construct and operate the proposed facility.

4) Discharge to an Incinerator Device. Discharge of ~~to~~ septage to an incinerator must be approved by the IEPA or the owner/operator of the incinerator must have a permit from the IEPA to receive septage from the contractor.

5) Discharge to a Sanitary Landfill. Discharge of septage to a sanitary landfill must be approved by the IEPA or the owner/operator of the landfill must have a permit from the IEPA to receive the septage from the contractor.

g) Methods for the disposal of waste from portable toilets shall be as follows:

1) Discharge to a Municipal Sanitary Sewer System. Discharge to a municipal sanitary sewer system is approved from private sewage disposal systems when the contractor has written approval from the municipality to discharge septage into the system.

2) Discharge to Sludge Lagoons or Sludge Drying Beds. Discharge to a sludge lagoon or drying bed must be approved by the Illinois Environmental Protection Agency (IEPA) (35 Ill. Adm. Code 309) or the owner/operator of the lagoon or drying bed must have a permit from the IEPA to receive septage from the contractor. If the contractor is going to construct a sludge lagoon or drying bed, a permit will be necessary from the IEPA to construct and operate the proposed facility.

3) Discharge to an Incinerator Device. Discharge of septage to an incinerator must be approved by the IEPA or the owner/operator of the incinerator must have a permit from the IEPA to receive septage from the contractor.

4) Discharge to a Sanitary Landfill. Discharge of septage to a sanitary landfill must be approved by the IEPA or the owner/operator of the landfill must have a permit from the IEPA to receive the septage from the contractor.

~~f~~h) "Other Wastes" The following shall not be disposed of by application to agricultural land: ~~Automatic grease, oil, grit, and similartype wastes shall not be applied to agriculatural land.~~

1) Waste from a portable toilet; and

2) Holding tank waste as provided in Section 905.140(a)(4).

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.180 Examinations for Licensure

a) Applications

1) Each person who desires to apply for admittance to the examination for a Private Sewage Disposal System Installation Contractor license or a Private Sewage Disposal System Pumping Contractor license shall file an application for examination on forms provided by the Department. These forms may be obtained by writing to the Illinois Department of Public Health, Division of Environmental Health ~~,--535-West--Jefferson--Street,--Springfield,--Illinois-62761~~.

2) Examination dates and locations shall be established by the Department. A completed application, a photograph of the applicant, and a fee of $25.00 must be filed with the Department at least 30 days prior to the examination date.

b) Examination Requirements and Results

1) Installation License Examination. The examination for a Private Sewage Disposal System Installation Contractor license shall test the applicant's knowledge of the design, installation, operation, maintenance, repairing and servicing of private sewage disposal systems.

2) Pumping Licensing Examination. The examination for a Private Sewage Disposal System Pumping Contractor license shall test the applicant's knowledge of the pumping, hauling, and disposal of wastes removed from private sewage disposal systems.

3) Individuals desiring both the installation contractor license and pumping contractor license must pass the examination for each license.

4) Passing Grade. The examination shall consist of questions with a combined grade value of 100 points. In order to successfully pass the examination, a grade of not less than 75 must be obtained.

5) Failure to Pass. Any person who fails to pass the examination shall be admitted to a subsequent regularly scheduled examination after filing a new application and fee with the Department in accordance with this Section ~~905.180(a)~~. However, persons who fail to pass the exam 2 times in a calendar year shall be required to wait at least one calendar year from the date of the last examination before taking the examination again.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.190 Installation Approval

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a) Plan approval ~~must~~ shall be obtained from the Department or local authority prior to beginning any construction of a new private sewage disposal system. A new private sewage disposal system shall consist of, but not necessarily be limited to, the following:

1) A system where a septic tank is replaced or where a major component of the system is removed or added. Examples of major components would be the replacement or addition of an aeration unit, recirculating sand filter, sand filter, seepage pit, seepage bed or lagoon.

2) A system where the size of the absorption field is increased in size by 25% or more or where 25% or more of the existing absorption field is removed and replaced with new piping and backfill material.

b) Submittal for approval shall be made on the forms provided by the Department or local authority. At a minimum, the necessary information which must be submitted to the Department or local authority for approval shall consist of:

1) Plans or drawings to scale indicating lot size with dimensions showing the location of the system, type of system to be constructed, the dimensions and the length of lateral to be installed showing type of backfill material if applicable, distances to water lines, water wells, potable water storage tanks and buildings, site elevations and ground surface elevations sufficient to determine the elevation of system components and the slope of the ground surface, location of sanitary sewer, if available, within 200 feet of the property and typical cross section of the system.

2) Number of bedrooms or design volume.

3) Soil investigation results or ~~Percolation~~ percolation test results and the separation distance from the trench bottom to a limiting layer ~~if applicable~~. The private sewage disposal system installation contractor or homeowner shall submit information with the plan approval application or local authority permit application that a limiting layer does not exist within the distances provided in Section 905.60(a)(7)(A) of this Part.

4) ~~Owners~~ Owner's name and address.

5) Name and signature of applicant.

c) ~~Contractors~~- Persons who construct, install, repair or modify a private sewage disposal system shall notify the Department or local authority at least 48 hours ~~two days~~ prior to commencement of the work.

d) If any person constructs, installs, repairs or modifies a private sewage disposal system without complying with the requirements of subsections (a) through (c) of this Section and backfills any portion of the system or covers any portion of the system with earth, cinders, gravel, shale or any other material which will prevent the Department or local authority from viewing the system to determine compliance with this Part, the property owner and/or private sewage disposal

installation contractor shall uncover the backfilled or covered portions of the system.

e) Contractor Responsibility. The private sewage disposal system installation contractor is responsible for the following:

1) Constructing, installing, repairing, modifying or maintaining the private sewage disposal system in accordance with this Part.

2) Percolation test results and the sewage disposal system which is designed and constructed using those results. Acceptance of percolation tests from other sources does not relieve the installation contractor's responsibility.

3) Providing the results of soil classification information and/or percolation tests used to design a private sewage disposal system to the property owner and copies of this information shall be retained by the installation contractor for at least 5 years.

4) Providing service to aerobic treatment plants at least equal to Section 905.100(g).

f) Soil Classifier Responsibility. The soil classifier or Illinois licensed professional engineer shall be responsible for the accuracy of the information in soil investigations used to design private sewage disposal systems.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.200 Licenses and Fees

a) An individual may obtain a license as a Private Sewage Disposal System Pumping Contractor or a Private Sewage Disposal System Installation Contractor upon successfully passing the examinations given for each, then, making application on forms provided by the Department and submitting the annual license fee of $50.00 to the Department.

b) *Each person who holds a currently valid plumbing license issued under the "Illinois Plumbing License Law"* ~~{Ill. Rev. Stat. 1985, ch. 111, par. 1101 et. seq.}~~ [225 ILCS 320] *is are not required to pay an annual license fee, but must comply with all other provisions of the Act and this Part.* ~~{Ill. Rev. Stat. 1985 ch. 111 1/2, par. 116.305(a)}~~ [225 ILCS 225/5(a)]

c) The fee to be paid for the annual renewal of either a Private Sewage Disposal System Pumping Contractor or a Private Sewage Disposal System Installation Contractor license shall be $50.00.

d) The fee to be paid for the reinstatement of a Private Sewage Disposal System Pumping Contractor license or a Private Sewage Disposal System Installation Contractor license which has expired for a period of less than 3 years shall be $20.00, plus all lapsed renewal fees.

e) A license which has expired for more than 3 years may be restored only by passing the written examination and paying the required fees.

f) A person who does not obtain a license within 2 years after successfully completing the appropriate examination shall be required

to file a new application and fee to the Department in accordance with Section 905.180(a) and again successfully pass the examination prior to applying for a license.

~~f)~~g) *No reinstatement fee will be charged and no examination will be required of an applicant who is seeking reinstatement within two years of terminating military service, upon payment of annual license fee and submission of evidence of military service.* ~~{Ill. Rev. Stat. 1985 ch. 111 1/2 par. 116.305 (b)}~~ [225 ILCS 225/5(b)]

(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.210 Notification of Disposal Site (Repealed)

~~Annually the private sewage disposal system pumping contractor shall:~~

~~a) Notify the Department or local public health authority of the sites utilized for disposal.~~

~~b) Provide an annual estimate of the total gallons of septage disposed of at each site.~~

(Source: Repealed at 19 Ill. Reg. _____, effective _____)

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Section 905.APPENDIX A Illustrations and Exhibits

Section 905.ILLUSTRATION A Quantity of Sewage Flows

TYPE OF ESTABLISHMENT	Unit (per)	Gallons Per Day
Permanent Residential Dwellings		
Single Family	bedroom	200
Multi-Family	bedroom	200
Individual Mobile Homes	bedroom	200
Mobile Home Parks	space	400
Boarding Houses	person	50
Rooming Houses	resident	40
Institutions		
Hospitals, Medical	bed	250
Hospitals, Medical	employee	15
Hospitals, Mental	bed	150
Hospitals, Mental	employee	15
Long-Term Care Institutions	bed	125
Long-Term Care Institutions	employee	15
Prison	inmate	150
Prison	employee	15
Schools		
Boarding School	person	150
Schools Without Cafeteria or Showers	person	15
Schools W/Cafeteria & Showers	person	25
Schools W/Cafeteria or Showers	person	20
Travel		
Airports	passenger	5
Railway Stations	passenger	5
Bus Stations	passenger	5
Highway Rest Areas	traveler	5
Recreational & Seasonal Areas		
Campgrounds W/Mobile Homes	site	150

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TYPE OF ESTABLISHMENT	Unit (per)	Gallons Per Day
Swimming Pools & Bathing Beaches	person	10
Comfort Sta. W/Toilets & Showers	space	35
Comfort Sta. W/No Showers	space	25
Day Camps W/O Meals	person	25
Day Camps W/Meals	person	35
RV Parks W/Water and Sewer Hooks-ups	space	50
Cottages and/or Small Dwellings W/Seasonal Occupancy	bedroom	150
Picnic Parks W/Toilet Facilities Only	person	10
Youth Camps W/O Cafeteria	person	50
Youth Camps W/Cafeteria	person	60
Migrant Labor Camps	person	150
Sanitary Dump Station for Unsewered Site	site	20
Campground W/Central Bath and Toilet Facilities	person	35
Commercial, Industrial & Misc.		
Country Clubs, No Kitchen	member	25
Hotels & Motels	bed	50
Places for Public Assembly	person	5
Theaters	seat	5
Churches W/O Kitchen	seat	3
Churches W/Kitchen	seat	6
Restaurants	meal	10
Restaurants W/Bar & Cocktail	meal	12
Offices & Day Workers	person	15
Shopping Centers	(per 1000 Sq. Ft. of Floor Area)	250
Stores	toilet	400
Service Stations (served)	vehicle	10
Laundries	customer	50
Construction Camps or Sites, Factories W/Toilets & Showers	person	35
W/Toilets, No Showers	person	20

~~GALLONS PER PERSON PER DAY~~

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TYPE OF ESTABLISHMENT	Unit (per)	Gallons Per Day
~~Type of Establishment~~	~~(Unless Otherwise Noted)~~	
~~Permanent Dwellings~~		
~~Board House~~	~~bed~~	~~50~~
~~Boarding Schools~~	~~bed~~	~~100~~
~~Institutions, Other than hospitals~~	~~bed~~	~~125~~
~~Mobile Homes, Individual~~	~~bedroom~~	~~200~~
~~Mobile Home Parks~~	~~space~~	~~250~~
~~Mult Family Dwellings~~	~~bedroom~~	~~150~~
~~Rooming Houses~~	~~bed~~	~~40~~
~~Single Family Dwellings~~	~~bedroom~~	~~200~~
~~Travel and Recreational Facilities~~		
~~Airports, Railway Stations, Bus Stations~~	~~passenger~~	~~5~~
~~Campgrounds~~		
~~Comfort Station w/toilets & showers~~	~~space~~	~~35~~
~~Comfort Station w/toilets, no showers~~	~~space~~	~~25~~
~~Day camps, no meals~~	~~person~~	~~25~~
~~Travel trailer parks with water and sewer hook ups~~	~~space~~	~~50~~
~~Cottages and/or Small Dwellings with seasonal occupancy~~	~~bedroom~~	~~150~~
~~Country Clubs~~	~~member~~	~~25~~
~~Highway Rest Areas~~	~~person~~	~~5~~
~~Hotels and Motels~~	~~bed~~	~~50~~
~~Picnic Parks~~	~~person~~	~~5~~
~~Places for Public Assembly~~	~~person~~	~~5~~
~~Swimming Pools and Bathing Beaches~~	~~person~~	~~10~~
~~Theatres~~		
~~Movie~~	~~seat~~	~~5~~
~~Drive in~~	~~car space~~	~~10~~
~~Commercial, Industrial, and Miscellaneous~~		
~~Churches~~	~~seat~~	~~3~~
~~With kitchens, add~~	~~meal~~	~~3~~
~~Construction Camps or Sites, Factories~~		
~~With toilets and showers~~	~~person~~	~~35~~
~~With toilets, no showers~~	~~person~~	~~20~~
~~Hospitals~~	~~bed~~	~~250~~

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~~Laundries~~	~~customer~~	~~50~~
~~Offices and other day workers~~	~~person~~	~~15~~
~~Restaurants, with toilets~~	~~meal~~	~~10~~
~~Restaurants, without toilets~~	~~meal~~	~~3~~
~~Additional for bars and cocktail lounges~~	~~person~~	~~2~~
~~Schools~~		
~~Without cafeterias or showers~~	~~person~~	~~15~~
~~With cafeterias and showers~~	~~person~~	~~25~~
~~With cafeterias or showers~~	~~person~~	~~20~~
~~Service Stations~~	~~vehicle served~~	~~5~~
~~Shopping Centers~~	~~1000 sq. ft. floor area~~	~~250~~
~~Stores~~	~~toilet room~~	~~400~~

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 905.ILLUSTRATION C List of Approved Plastic Pipe for Private Sewage Disposal System ~~Septic Uses~~

TYPES OF PIPES	ASTM STANDARD	BUILDING SEWER ~~(4)~~(1) OR COMMON COLLECTOR	SEWER LINES(1)	ALL ~~DISTRIBUTION LINES~~ SUBSURFACE SEEPAGE SYSTEMS
		5 ft. from building to septic-aeration tank to 56 ft. beyond the septic tank, aeration tank or distribution box	Additional treatment facilities and sand filter ~~collection~~ distribution lines and ~~distribution~~ collection lines	
PVC (Type PS 46)	F789-82	x	x	x
ABS (DWV Schedule 40)	F628-85	x	x	x
ABS (DWV Schedule 40)	D2661-78	x	x	x
ABS	D1527-77	x	x	x
ABS (Sewer Pipe)	D2751-80	x(2)	x(2)	x(2)
PVC	D1785-76	x	x	x
PVC (DWV Schedule 40)	D2665-78	x	x	x
PVC (DWV Schedule 40)	F891-86	x	x	x
PVC (Type PSM) (SDR35)	D3034-80	x(2)	x(2)	x(2)
PVC (Type PSP) (SDR35)	D3033-81	x(2)	x(2)	x(2)
~~PVC (Type PS 46)~~	~~F789-82~~	~~x~~	~~x~~	~~x~~
PVC (Sewer & Drain PS-50)	F891-86	x	x	x
PVC (Sewer & Drain PS-25)	F891-86	x	x	
PVC (Corrugated-Smoothwall)	F949-85	x	x	
PVC (Std. or Perforated)	D2729-80		x	x
PE (Smoothwall)	F810-83		x	x
	AASHTO			

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	Standard M252-851	
PE (Corrugated-Perforated)	F405-82 ~~(3)~~ (Heavy Duty Only)	x
PE (Corrugated-(Perforated)	F667-84	x

x - Indicates approved use.

(1)- Commingling of plastic materials shall not be done within this area except through the use of proper adapters. (See Illinois Plumbing Code (77 Ill. Adm. Code 890~~.~~.) When the building sewer is of a type of material that is different from the building drain, proper transition fittings shall be used.

(2)- Pipe shall be ~~note have an~~ SDR (Standard Dimension Ratio) ~~number greater than~~ 35 only.

~~3- Heavy Duty (only)~~

Note: The last two numbers of the ASTM Standard indicates the date of the edition.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 905.ILLUSTRATION D Location of Components of Private Sewage Disposal Systems~~(1)~~

COMPONENT PART OF SYSTEM	MINIMUM DISTANCE ALLOWABLE FROM: Cistern Well, or Suction Line from Pump To Well	Water Supply Line(3) Pressure	Lake, Stream In ground Swimming Pool or Other Body of Water	Property Dwelling	Property Line	Artificial Drain ~~Field Drain Tile~~
	FEET	FEET	FEET	FEET	FEET	FEET
Building Sewer(2)	50	10	25	-	-	-
Septic Tank or Aerobic Treatment Plant	50	10	25	5	5	-
Distribution Box	75	10	25	10	5	-
Subsurface Seepage System	75	25	25	10	5	10
Sand Filter	75	25	15	10	5	10
Privy	75	25	25	20	5	10
Waste Stabilization Pond	75	25	25	20	5	10
~~Seepage Pit~~	~~100~~	~~25~~	~~25~~	~~10~~	~~5~~	~~10~~
Surface Discharge Effluent Line(2)	50	10	-	-	5	-
Effluent Receiving Trench	75	25	15	10	5	10

1- These distances have been determined for use in clay, silt and loam soils only. The minimum distances required for use in sand or other types of soil shall be determined for the proposed private sewage disposal system and approved by this Department. Such approval will be given where the Department determined that the soil will provide treatment of the sewage.

2- The building sewer or surface discharge effluent line may be located to within 10 feet of a well or suction line from the pump to the well when cast iron pipe with mechanical joints or Schedule 40 PVC pipe with water-tight joints is used for the building sewer or surface discharge effluent line.

3- See Section 905.20(d) for additional details on water line and sewer separation. This includes lawn irrigation piping.

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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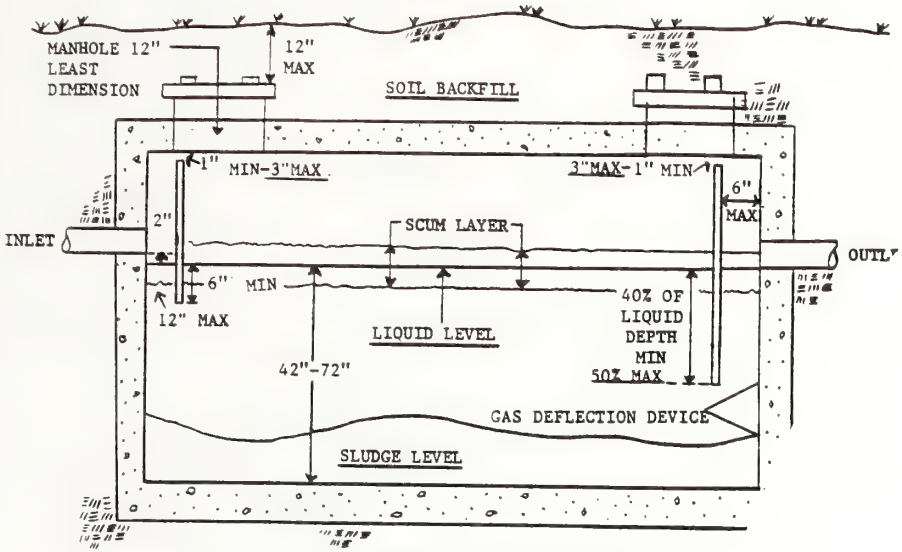
Section 905.ILLUSTRATION E Septic Tanks

Section 905.EXHIBIT A Septic Tank with Slip-In Baffles



SEPTIC TANK WITH SLIP-IN BAFFLES

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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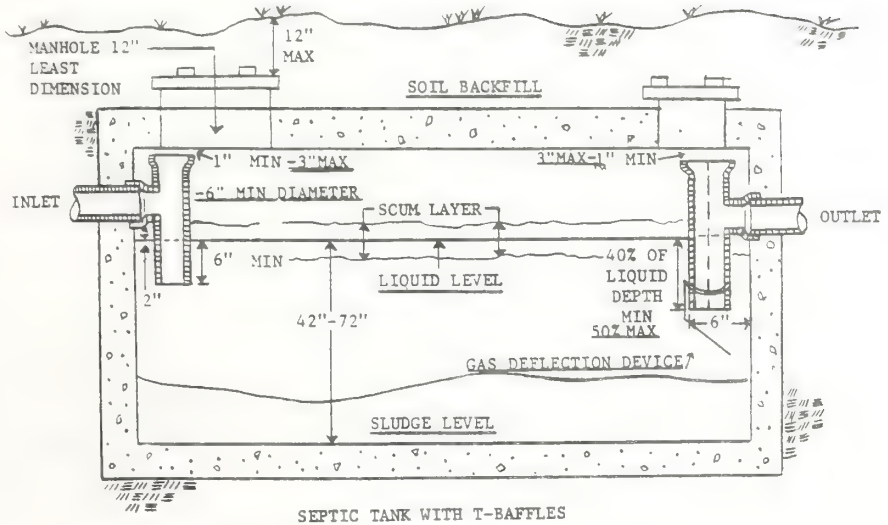
Section 905.EXHIBIT B Septic Tank with T-Baffles



SEPTIC TANK WITH T-BAFFLES

ILLINOIS REGISTER 3369
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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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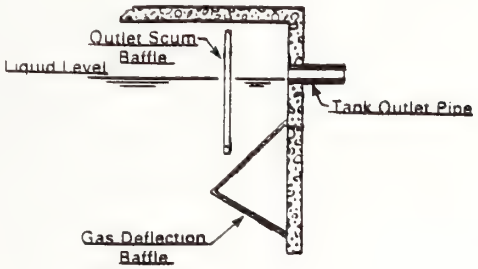
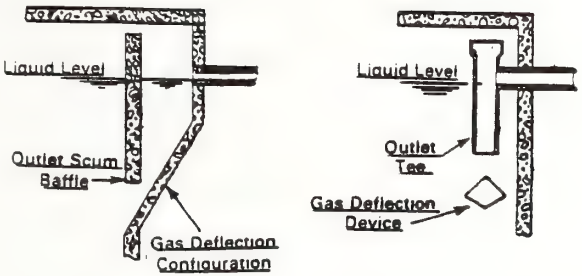
Section 905.EXHIBIT C Typical Gas Deflection Devices





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(Source: Added at 19 Ill. Reg. _____, effective _____)

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Section 905.ILLUSTRATION F Minimum Volumes for Septic Tanks Serving Residential Units

NUMBER OF BEDROOMS	MINIMUM LIQUID CAPACITY OF TANK (GALLONS)	MINIMUM LIQUID CAPACITY OF TANK (GALLONS) WHEN GARBAGE GRINDER IS USED
2 or less	750	~~1250~~1125
3	1000	1500
4	1250	2000
5	1500	2200
6	1750	2600
7	2000	3000

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 905.ILLUSTRATION G Instructions for Conducting Percolation Tests

Percolation tests shall not be made in frozen ground or ground that has been filled in the preceeding 12 months. Percolation tests shall be performed in accordance with the following procedures:

~~TYPE-OF-TEST-HOLE:~~ 1. Number and Location of Percolation Tests. Select an area where the seepage field will be located. When digging the holes, avoid animal burrows, large root channels, etc. At least 3 separate percolation tests shall be performed at the site of each proposed disposal area. The percolation test holes shall be at least 50 feet apart. At least one hole shall be located at the lowest elevation of the proposed absorption field area. ~~Three-holes-should be-made-if-channels-or-a-variation-in-soil-occurs;~~ ~~the~~ The ~~two~~ 2 holes with the highest ~~most-similar~~ results shall ~~can~~ be used to determine percolation rate.

2. Depth of Percolation Test Hole. Dig or bore the holes with horizontal dimensions approximately ~~four~~ 4 to ~~six~~ 6 inches in diameter to the depth of the proposed seepage field or seepage bed.

3. Preparation of Test Hole: ~~PREPARATION-OF-TEST-HOLE:~~

   a) Carefully pick the bottom and sides of the hole with a knife blade or sharp pointed instrument to remove smeared or smoothed soil and to provide a natural soil interface into which water may percolate.

   b) Remove all loose material from the hole.

   c) Add ~~two~~ 2 inches of coarse gravel to protect the bottom from scouring and sediment. A removable hardware cloth screen to line the lower part of the hole also helps prevent sloughing of the hole sides during testing.

4. ~~SATURATION-AND-SWELLING-OF-SOIL:~~ Saturation and Swelling of Soil: ~~In-moist soil,-keep-water-in-the-hole-by-carefully-filling-the-hole-and-keeping--it full--for--at-least-four-hours-before-conducting-the-test:~~ It is important to distinguish between saturation and swelling. Saturation means the void spaces between soil particles are full of water. This can be accomplished in a very short period of time. Swelling is caused by the intrusion of water into the individual soil particle. This is a slow process, especially in a clay type soil, and is the reason for requiring a prolonged soaking period.

   a) On the day prior to conducting the percolation test, carefully fill the hole with water and keep it full for at least 4 hours. The percolation test shall be conducted on the day following this presoaking at least 18 hours after presoaking is completed but prior to 30 hours after presoaking is completed. Cover the hole during this 18-30 hour waiting period. In sandy soils with greater than 70% sand and less than 15% clay (sand and loamy sand), after the 4 hour

presoak, a percolation test may be attempted without the 18 hour waiting period. If the percolation test results are greater than 45 minutes for a 6 inch drop in water, the test must be repeated after the 18 hour waiting period. If the percolation test results are 45 minutes or less, the percolation rate shall be used to size the system.

b) On the day of conducting the percolation test, carefully fill the hole with water to 12 inches above the gravel.

c) Allow the water level to drop to a point 6 inches above the gravel. If the water does not fall from 12 inches to 6 inches in 6 hours the percolation test is terminated, and an alternate system is required.

d) Measure the last 6 inch drop in water level at thirty minute intervals until all the water has seeped away.

~~At the time of the test, adjust the water level to twelve inches above the gravel. Allow the level to drop six inches, then commence measuring the drop in water level at thirty minute intervals until all the water has seeped away.~~

~~WARNING~~Warning: Under no conditions shall measurements be taken ~~or~~ from water filled to the top of the hole or on water ~~twelve~~ 12 inches deep in the hole. Such results are completely invalid and will not be accepted. ~~SUCH RESULTS ARE COMPLETELY INVALID AND WILL NOT BE ACCEPTED.~~ Results from the last 6 inches of drop in water are the only results which will be accepted.

5. ~~RECORDING OF RESULTS~~ Recording of Results: Record results of all tests as the total minutes required for the last ~~six~~ 6 inches of seepage. ~~†~~If the last ~~six~~ 6 inches of water has not seeped away at the end of ~~six~~ 6 hours, the soil must be considered unsuitable for seepage field disposal and the appropriate statement marked on the results form.~~†~~ If there is more than a 30 minute difference between the highest 2 percolation tests, use the larger result or perform additional percolation tests.

6. Calculating the Percolation Rate: Add the total minutes required for the last 6 inches of water to fall from the 2 holes with the highest result and divide by 2. If the average is less than 60 minutes use the percolation rate of 60 minutes. If the average is greater than 60 minutes, refer to Section 905.Appendix A: Illustration H of this Part. Locate in the first column (Time (minutes) required for last 6 inches of water to fall) where the highest 2 hole average fits and use the next highest result as the percolation rate for sizing and design. An example of this procedure is as follows: If 3 percolation tests are conducted with results of 120 minutes, 140 minutes, and 155 minutes, the highest 2 hole average would be (140 + 155)/2 or 147.5 minutes. Looking at Section 905.Appendix A: Illustration H of this Part, the next highest result would be 150 minutes. The 150 minute rate would be used to size and design the subsurface seepage system.

7. Distribution of Results: The results of the percolation tests shall be

given to the homeowner and shall be retained by the contractor for at least ~~five~~ 5 years. The percolation test ~~date~~ data report shall be returned to the appropriate regional office or local authority.

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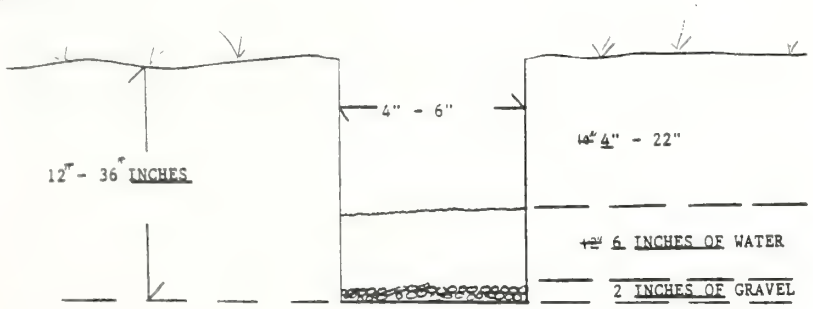
TEST HOLE:



~~At least two separate percolation tests shall be performed at the site of each proposed disposal area.~~

~~Percolation tests shall not be made in frozen grounds or ground that has been filled in the preceding twelve months.~~

	TEST HOLE #1		TEST HOLE #2		TEST HOLE #3	
READING #	TIME (in min.)	WATER LEVEL (in inches)	TIME (in min.)	WATER LEVEL (in inches)	TIME (in min.)	WATER LEVEL (in inches)
1	0		0		0	
2	30		30		30	
3	60		60		60	
4	90		90		90	
5	120		120		120	
6	150		150		150	

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7	180	180	180
8	210	210	210
9	240	240	240
10	270	270	270
11	300	300	300
12	330	330	330
13	360	360	360

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 905.ILLUSTRATION H Subsurface Seepage System Size Determination

Section 905.EXHIBIT A Gravel System

Time (minutes) required for last 6 inches of water to fall	FOR RESIDENTIAL USE Required Absorption Area (ft(2)/bedroom)	FOR INSTITUTIONAL OR COMMERCIAL USE Allowable application rate (GPD/ft(2))(5)	Depth from bottom of the trench to the limiting layer
~~10---30~~	~~130~~	~~1.6~~	
18 - 60	~~165~~200	~~1.2~~1.0	
90	210	~~1.0~~.95	3 feet
120	235	~~0.9~~.85	
150	265	~~0.8~~.75	
180	290	~~0.7~~.69	
240	320	~~0.6~~.62	
300	350	~~0.6~~.57	2 feet
360	385	~~0.5~~.52	

NOTE:

~~1. If there is more than a 30 minute difference between percolation tests, use the larger results, or perform another percolation test.~~

~~2~~1. Absorption area is figured as trench bottom area in absorption trenches~~, effective sidewall area in seepage pits~~, and bottom area in seepage beds.

~~3~~2. Seepage beds require 1 1/2 times the seepage field absorption area specified.

~~4. Over 180 is unsuitable for seepage pits.~~

~~5~~3. Over 360 is unsuitable for subsurface seepage systems.

~~6~~4. Under 18 is unsuitable for subsurface seepage systems.

5. Divide the required total gallons per day by this number to get the

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number of square feet required.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 905.EXHIBIT B ~~Gravel-less~~Gravelless System

Time (minutes) required for last 6 inches of water to fall	FOR RESIDENTIAL USE Required Absorption ~~Area~~ Piping (Linear feet/Bedroom)		FOR INSTITUTIONAL OR COMMERCIAL USE Allowable application rate (GPD/Linear Foot)(3)		Depth from the bottom of the trench to the limiting layer
	8 inch	10 inch	8 inch	10 inch	
~~18-30~~	~~65~~	~~45~~	~~3.2~~	~~4.8~~	
18 - 60	~~85~~100	~~55~~70	~~2.4~~2.00	~~3.6~~3.00	
90	105	70	~~2.0~~1.90	~~3.0~~2.86	3 feet
120	120	80	~~1.8~~1.66	~~2.7~~2.50	
150	135	90	~~1.6~~1.48	~~2.4~~2.22	
180	145	100	~~1.4~~1.38	~~2.1~~2.00	
240	160	110	~~1.2~~1.25	~~1.8~~1.82	
300	175	120	~~1.1~~1.14	~~1.6~~1.66	2 feet
360	195	130	1.0	~~1.5~~1.54	

NOTE:

~~1. If there is more than a 30 minutes difference between percolation tests, use the larger results, or perform another percolation test.~~

~~2. Absorption area is figured as trench bottom area in absorption trenches and bottom area in seepage beds.~~

~~3. Seepage beds require 1 1/2 times the seepage field absorption area specified.~~

~~4.~~1. Over 360 is unsuitable for subsurface seepage systems.

~~5.~~2. Under 18 is unsuitable for subsurface seepage systems.

3. Divide the required total gallons per day by this number to get the number of lineal feet required.

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 905.ILLUSTRATION I Seepage Field Construction

Section 905.EXHIBIT A Standards-- Gravel System

Trench length, maximum length from point of discharge into seepage trench	100 feet
Trench bottom, minimum width	8 in.
Trench bottom, maximum width	36 in.
Trench bottom, minimum depth	18 in.
Trench bottom, maximum depth	36 in.
Trench bottom, slope	level
Distribution line, minimum diameter	4 in.
Distribution line, minimum earth cover	6 in.
Distribution line, maximum earth cover	24 in.
Distribution line, maximum slope	level

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 905.EXHIBIT C Standards---~~Gravel-less~~Gravelless System

STANDARDS FOR SEEPAGE FIELD CONSTRUCTION (GRAVELLESS) ~~(GRAVEL-LESS)~~

Trench Length, maximum length from point of discharge into system	100 feet
Trench Bottom, minimum width	18 inches
Trench Bottom, maximum width	24 inches
Trench Bottom, minimum depth	18 inches
Trench Bottom, maximum depth	36 inches
Trench Bottom, slope	level
Distribution Line, minimum inside diameter	8 inches
Distribution Line, maximum inside diameter	10 inches
Distribution Line, minimum earth cover	6 inches
Distribution Line, maximum earth cover	24 inches
Distribution Line, maximum slope	level

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 905.EXHIBIT D Size and Spacing - ~~Gravel-less~~ Gravelless System

SIZE AND SPACING FOR SEEPAGE FIELD CONSTRUCTION (~~GRAVEL-LESS~~GRAVELLESS)

Inside Diameter of Gravel-less Drainfield	Minimum Center to Center Spacing of Distribution Lines	Effective Absorption Area Per Lineal Foot of Trench
8 inches I.D.	7.0	2.0
10 inches I.D.	7.0	3.0

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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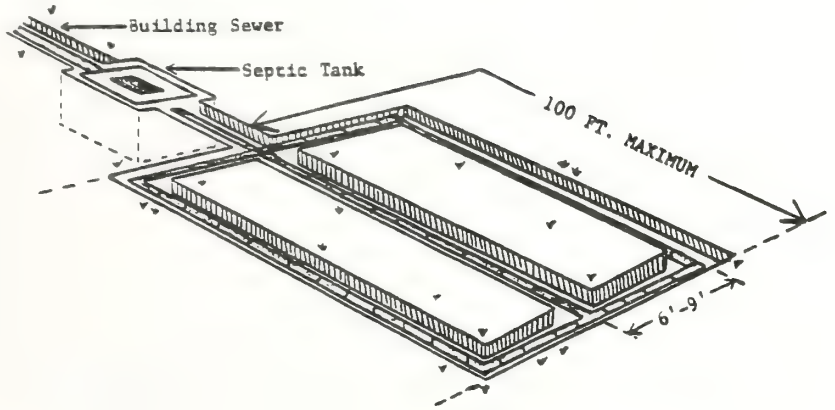
Section 905.ILLUSTRATION J Septic Tank Subsurface Seepage Field

Section 905.EXHIBIT A Plan View – Gravel System



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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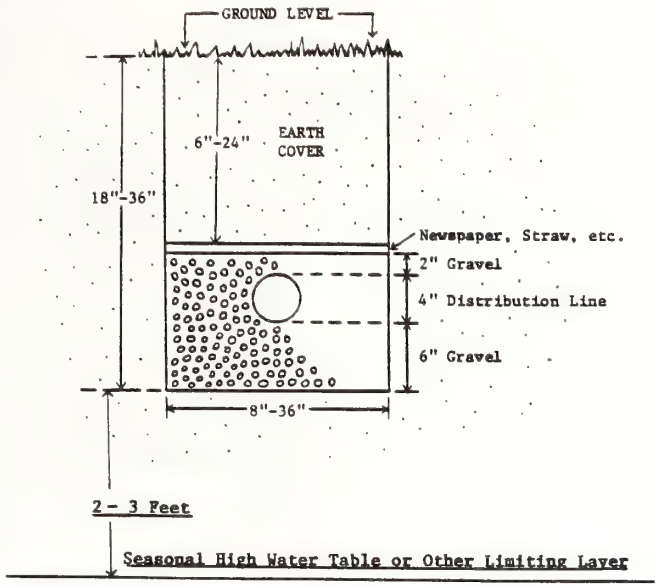
Section 905.EXHIBIT B Section View - Gravel System



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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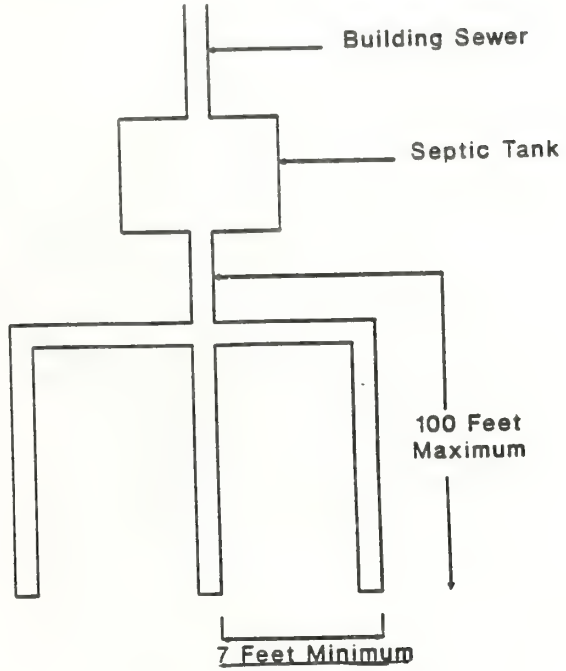
Section 905.EXHIBIT C Plan View - ~~Gravel-less~~ Gravelless System



PLAN VIEW

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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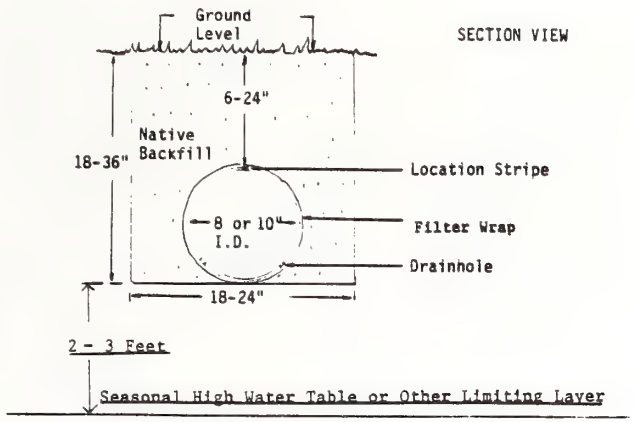
Section 905.EXHIBIT D Section View - ~~Gravel-less~~ Gravelless System



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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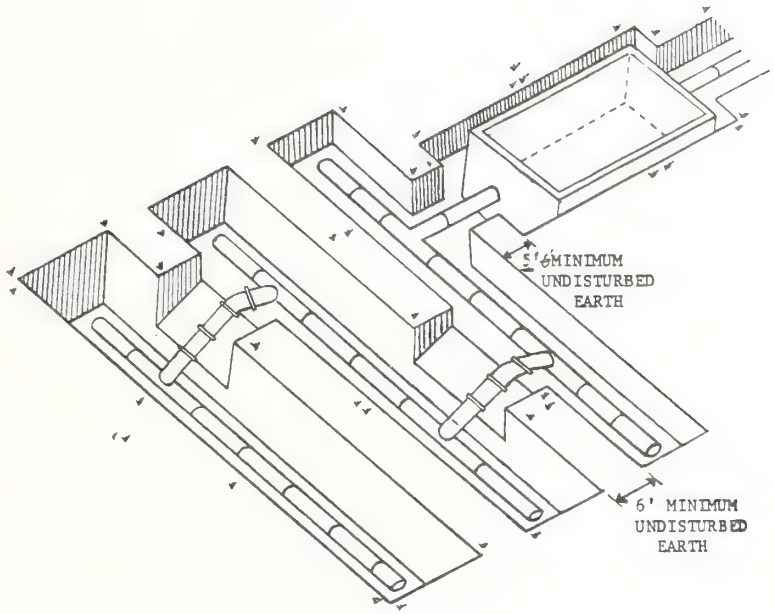
Section 905.ILLUSTRATION K Serial Distribution

Section 905.EXHIBIT A Plan View #1 - Gravel System



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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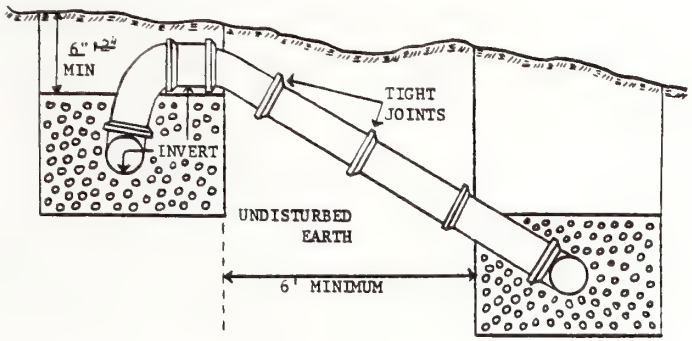
Section 905.EXHIBIT B Section View #1 - Gravel System



NOTE: Invert of the first relief line must be at least 6" 1 inch lower than invert of the septic tank outlets.

(Source: Amended at 19 Ill. Reg. _____, effective

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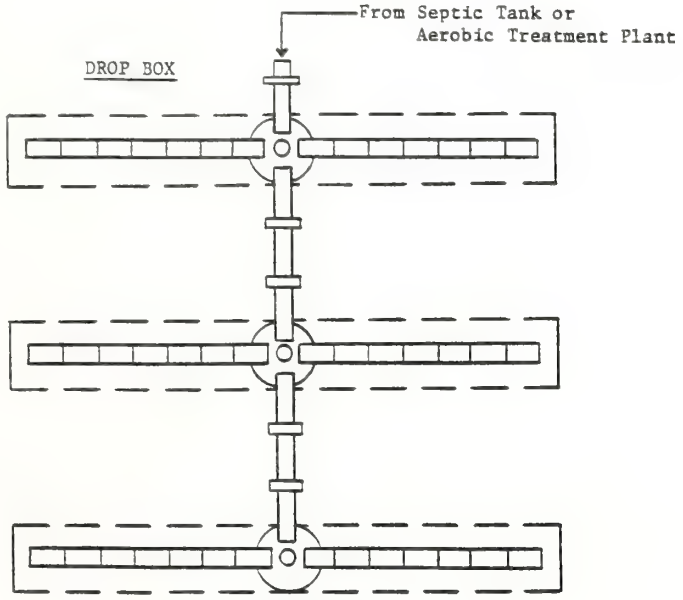
Section 905.EXHIBIT C Plan View #2 - Gravel System



PLAN VIEW

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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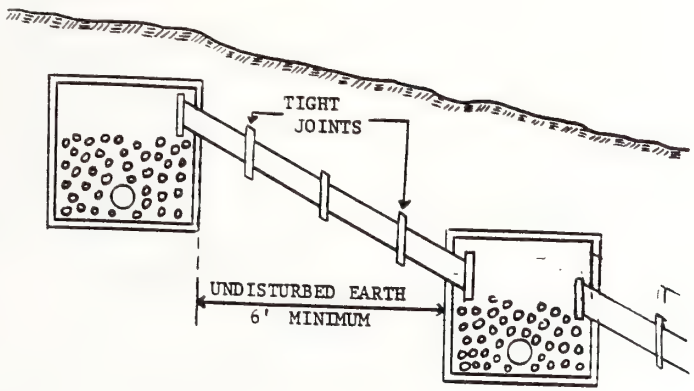
Section 905.EXHIBIT D Section View #2 - Gravel System



~~**-Differing-ground-slopes-over-subsurface-disposal-fields-may-require use-of-various-combinations-of-fittings.~~

(Source: Amended at 19 Ill. Reg. _____, effective

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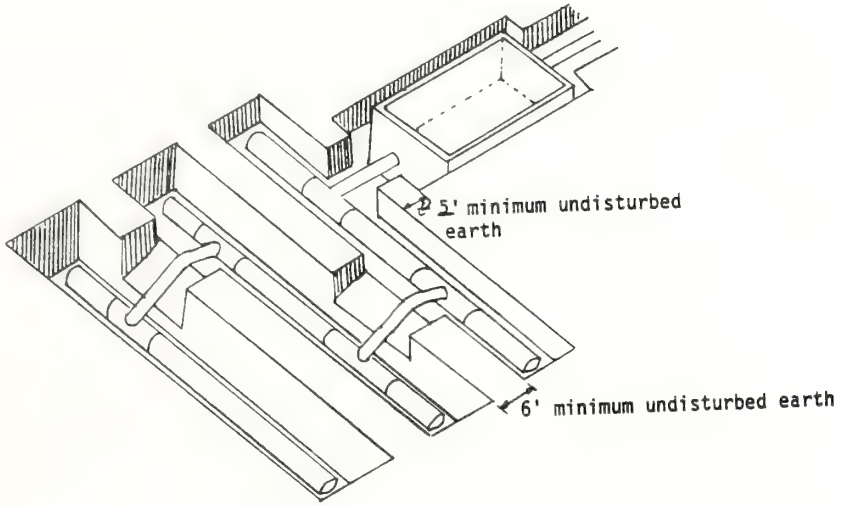
Section 905.EXHIBIT E Plan View #1 - Gravelless ~~Gravel-less~~ System



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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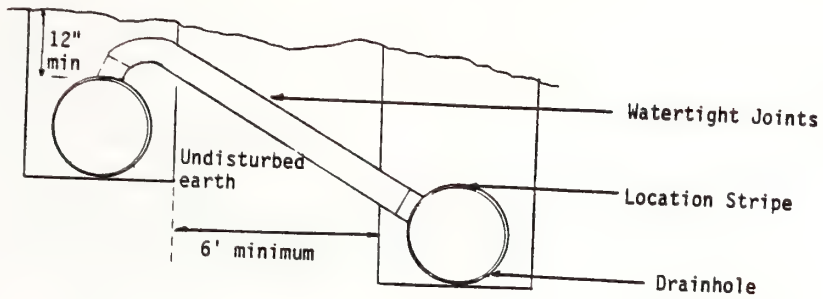
Section 905.EXHIBIT F Section View #1 - ~~Gravel-less~~ Gravelless System



NOTE: Invert of the septic tank outlet shall be at least one inch higher than the top of the

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gravelless pipe.
~~Bottom of inlet pipe from septic tank must be 1" higher than top gravel less pipe.~~

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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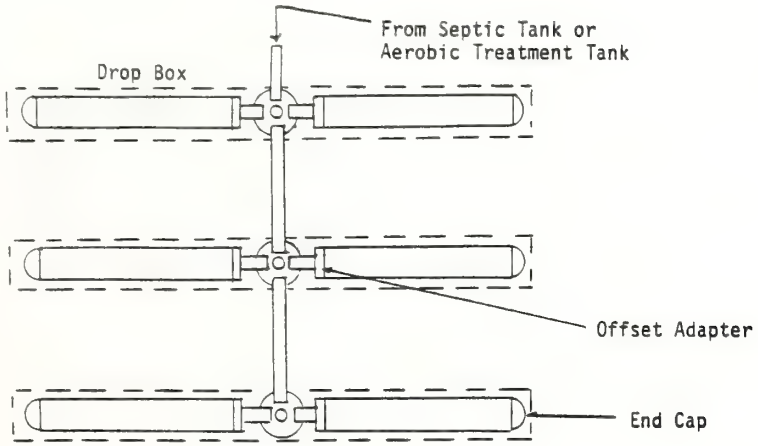
Section 905.EXHIBIT G Plan View #2 - Gravelless ~~Gravel-less~~ System



PLAN VIEW

(Source: Amended at 19 Ill. Reg. _____, effective

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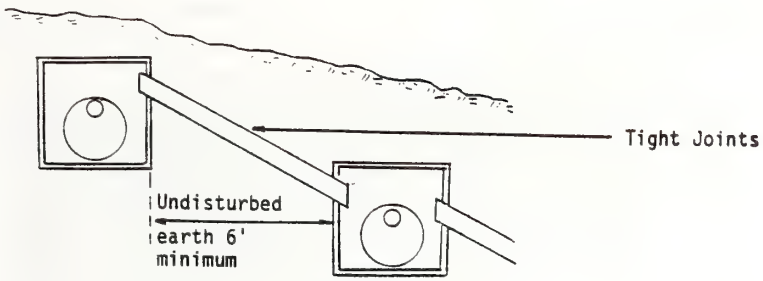
Section 905.EXHIBIT H Section View #2 - Gravelless ~~Gravel-less~~ System



(Source: Amended at 19 Ill. Reg. _____, effective

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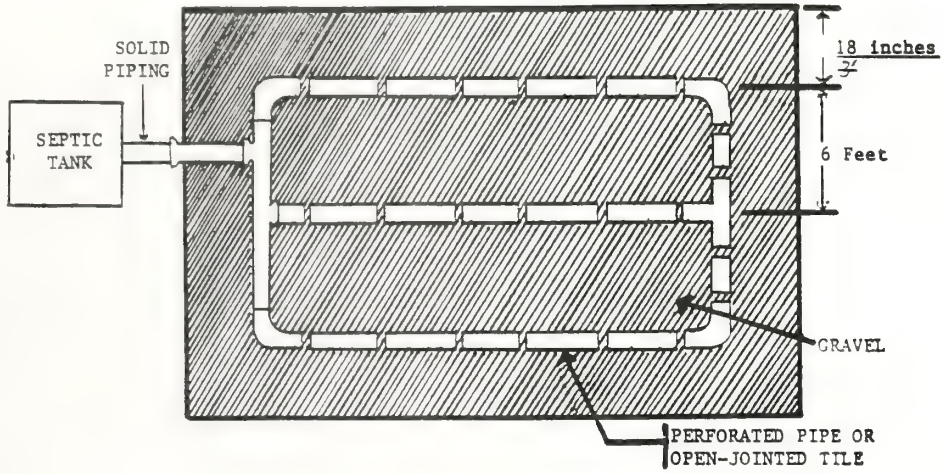
Section 905.ILLUSTRATION L Seepage Bed

Section 905.EXHIBIT A Plan View



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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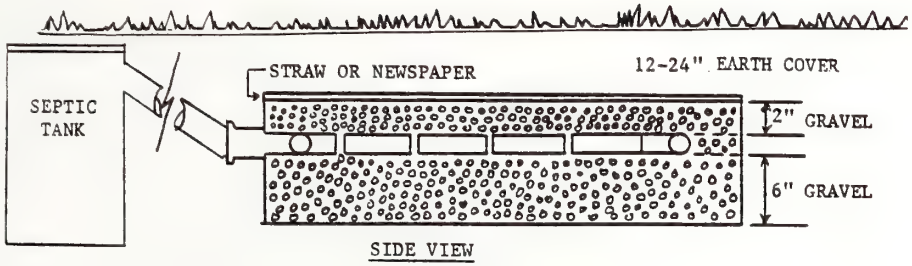
Section 905.EXHIBIT B Side View



SIDE VIEW

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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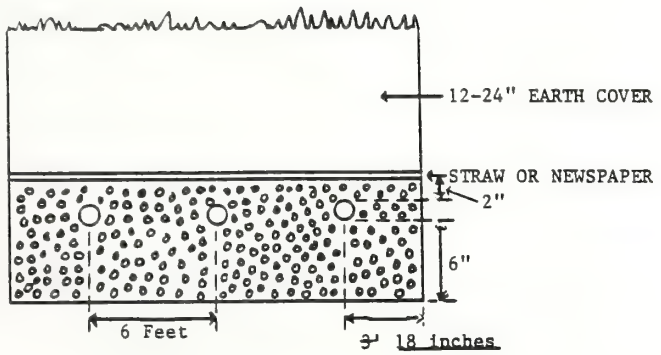
Section 905.EXHIBIT C End View



(Source: Section repeals, new Section added at 19 Ill. Reg. _____, effective _____)

Section 905.Appendix A — Illustrations and Exhibits
~~Section 905.~~Illustration M — Soil Suitability For On-Site Sewage Design ~~Seepage Pits~~
~~Section 905.~~Exhibit A — Loading Rates in Square Feet Per Bedroom and Gallons/Square Feet/Day ~~Vertical Wall Areas~~

Loading Rates in Square Feet Per Bedroom and Gallons/Square Feet/Day

Design Group	Soil Group (Most limiting Layer)	Minimum Separation To Limiting Layer (1)	Permeability Range	Size of System	
				Residential Req. Absorption (ft^2/bedroom)	Institutional/Commercial Allowable Application Rate (GPD/ft^2)
I	1A	N/A	Very Rapid	N/A	N/A
II	2A; 2B; 2K	3 feet	Rapid	200	1.0
III	3B; 3K	3 feet	High Moderately Rapid	220	0.91
IV	3A; 3C; 3L; 4B; 4K	3 feet	Low Moderately Rapid	240	0.84
V	4A; 4C; 4D; 4L; 4M; 5B; 5D	3 feet	Very High Moderate	265	0.75
VI	5C; 5E; 5K; 6F	3 feet	High Moderate	290	0.69
VII	5A; 5H; 6D	2 feet	Moderate	325	0.62
VIII	4N; 5I; 5L; 6A; 6E; 6G; 6K	2 feet	Low Moderate	385	0.52
IX(2)	5J; 5M; 6C; 6H; 6L; 7A; 7D; 7F	2 feet	High Moderately Slow	445	0.45
X(2)	6I; 7E; 7G; 8A	2 feet	Low Moderately Slow	500	0.40
XI(2)	5N; 6J; 6M; 7I; 7K	2 feet	Slow	740	0.27
XII(2)	7J; 7L; 8I	2 feet	Very Slow	1000	0.20
XII(2)	6N; 7M; 7N; 8J; 8N	N/A	N/A	N/A	0.00
XIII	9	SUBSURFACE DISPOSAL NOT RECOMMENDED			

NOTES: (1) Limiting layers include fragipans; bedrock; compact glacial tills; seasonal high water table or other soil profile features that will materially affect the absorption of liquid from the disposal field.

Section 905.Appendix A — Illustrations and Exhibits
~~Section 905.~~Illustration M — Soil Suitability For On-Site Sewage Design ~~Seepage Pits~~
~~Section 905.~~Exhibit A — Loading Rates in Square Feet Per Bedroom and Gallons/Square Feet/Day (Continued) ~~Vertical Wall Areas~~

(2) Soils in this group are less than the minimum percolation rate established in Section 905.Illustration H of this Part as suitable for subsurface seepage systems.

~~DIAMETER OF SEEPAGE PITS IN FEET~~ — ~~EFFECTIVE DEPTH BELOW INLET IN FEET~~

	~~1~~	~~2~~	~~3~~	~~4~~	~~5~~	~~6~~	~~7~~	~~8~~
~~3~~	~~9.4~~	~~19~~	~~28~~	~~38~~	~~47~~	~~57~~	~~66~~	~~75~~
~~4~~	~~12.6~~	~~25~~	~~38~~	~~50~~	~~63~~	~~75~~	~~88~~	~~101~~
~~5~~	~~15.7~~	~~31~~	~~47~~	~~63~~	~~79~~	~~94~~	~~110~~	~~126~~
~~6~~	~~18.8~~	~~38~~	~~57~~	~~75~~	~~94~~	~~113~~	~~132~~	~~151~~
~~7~~	~~22.0~~	~~44~~	~~66~~	~~88~~	~~110~~	~~132~~	~~154~~	~~176~~
~~8~~	~~25.1~~	~~50~~	~~75~~	~~101~~	~~126~~	~~152~~	~~176~~	~~201~~
~~9~~	~~28.3~~	~~57~~	~~85~~	~~113~~	~~141~~	~~170~~	~~198~~	~~226~~
~~10~~	~~31.4~~	~~63~~	~~94~~	~~126~~	~~157~~	~~188~~	~~220~~	~~251~~
~~11~~	~~34.6~~	~~69~~	~~104~~	~~138~~	~~173~~	~~207~~	~~242~~	~~276~~
~~12~~	~~37.7~~	~~75~~	~~113~~	~~151~~	~~188~~	~~226~~	~~264~~	~~302~~

(Source: Section repealed, new Section added at 19 Ill. Reg. _____, effective _____)

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Section 905.EXHIBIT B ~~Construction Views~~ Key for Determining Sewage Loading Rates

KEY FOR DETERMINING SEWAGE SUBSURFACE LOADING RATES (g/d/sq.ft.) FOR ILLINOIS SOILS (1)

Structure and Parent Material	Single grain; Granular / Platy (2)	Angular and Subangular Blocky; Prismatic									Structureless or Massive			
		Loess; Outwash						Till; Lacustrine						
		Weak		Moderate		Strong		Moderate; Strong			Loess; Outwash		Till (3); Lacustrine	
Moist Consistence	lo vfr fr	lo vfr	fr fi	fr	fi	fr	fi	fr	fi	vfi	vfr fr	fr	vfr fr	fi vfi
Texture	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1. Fragmental; Ext. or Very gravelly sand; Gravelly sand; Coarse sand; Gravelly loamy sand	>1.00 (4)	(5) N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2. Medium sand; Sand; Loamy coarse sand; Loamy sand; Coarse sandy loam	1.00	1.00	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1.00	N/A	N/A	N/A
3. Fine sand; Loamy fine sand	0.84	0.91	0.8 / 4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.91	0.84	N/A	N/A
4. Sandy loam; Fine sandy loam; Gravelly sandy loam; Gravelly loam; Gravelly silt loam	0.75	0.84	0.7 / 5	0.75	N/A	N/A	N/A	N/A	N/A	N/A	0.84	0.75	0.75	0.52
5. Loam; Silt loam; Very fine sandy loam; Sandy clay loam; Silt; Very fine sand; Loamy very fine sand	0.62	0.75	0.6 / 10	0.75	0.69	N/A	N/A	0.6 / 2	0.52	(6) 0.4 / 5	0.69	0.52	(6) 0.45	0.27 (6)
6. Silty clay loam (<35% c); Clay loam (<35% c)	0.52	N/A	(6) 0.4 / 5	0.62	0.52	0.69	0.52	(6) 0.4 / 5	(6) 0.40	(6) 0.2 / 7	0.52	(6) 0.45	(6) 0.27	0.00 (6)
7. Silty clay loam (>35% c); Clay loam (>35% c); Sandy clay (<40% c)	0.45 (6)	N/A	N/A	(6) 0.45	(6) 0.40	(6) 0.45	(6) 0.40	N/A	(6) 0.27	(6) 0.2 / 0	(6) 0.27	(6) 0.20	(6) 0.00	0.00 (6)
8. Sandy clay (>40% c) Silty clay	0.40 (6)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	(6) 0.20	(6) 0.0 / 0	N/A	N/A	N/A	0.00 (6)
9. Clay; Organics; Fragic; Fragipan; Lithic; Paralithic	SOIL PROPERTIES HAVE VERY SEVERE LIMITATIONS; SUBSURFACE DISPOSAL NOT RECOMMENDED													

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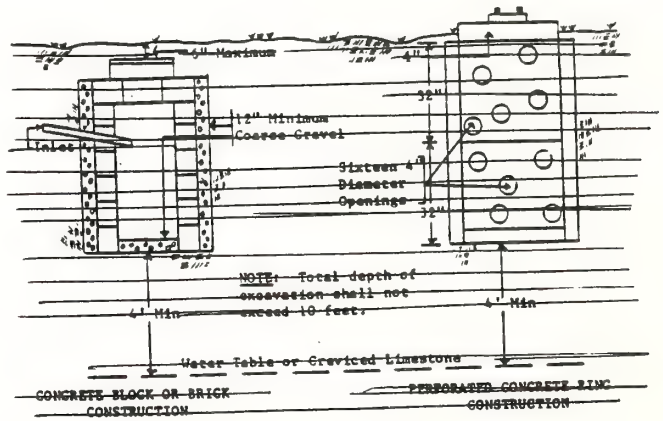
Section 905.Appendix A Illustrations and Exhibits
Illustration M Seepage Pits
Exhibit B Key for Determining Sewage Loading Rates (Continued) ~~Construction Views~~

FOOTNOTES:
(1) Disturbed soils are highly variable and require special on-site investigations.
(2) Moderate or strong platy structure for the soil textures in Group 5 have a loading rate of 0.40 g/d/ft. Platy structure having firm or very firm consistence and/or caused by mechanical compaction has a loading rate of 0.0 g/d/sq. ft.
(3) Weakly structured BC horizons and basal glacial tills structured by geogenic processes have the same loading rates as structureless glacial till.
(4) This soil group is estimated to have very rapid permeability and exceeds the maximum established rate in Section 905.Illustration H, Exhibit A of this Part.
(5) N/A means not applicable.
(6) These soil groups are estimated to have moderately slow to very slow permeability and is less than the minimum established rate in Section 905.Illustration H, Exhibit A of this Part.



(Source: Section repealed, new Section added at 19 Ill. Reg. _____, effective _____)

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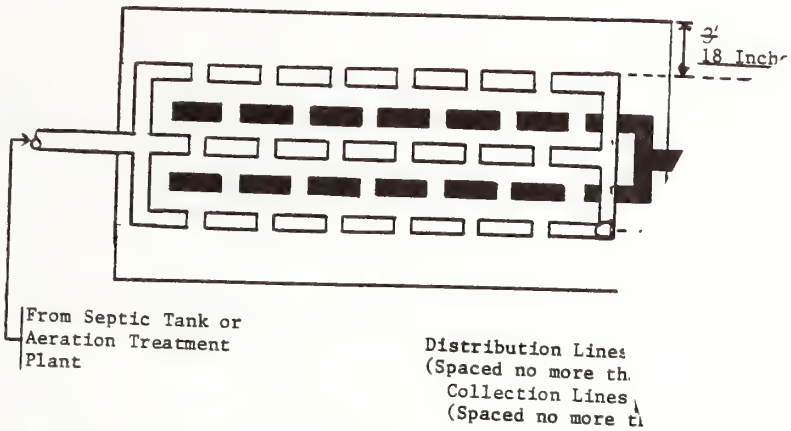
Section 905.ILLUSTRATION N Buried Sand Filter

Section 905.EXHIBIT A Plan View



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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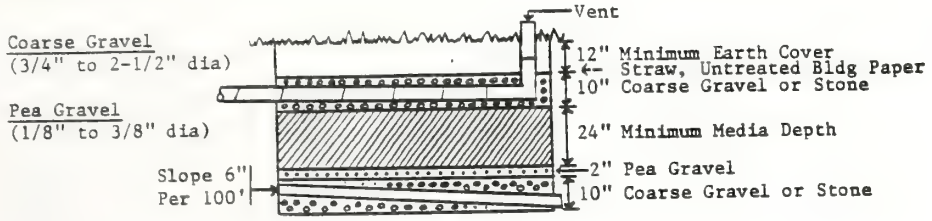
Section 905.EXHIBIT B Section View



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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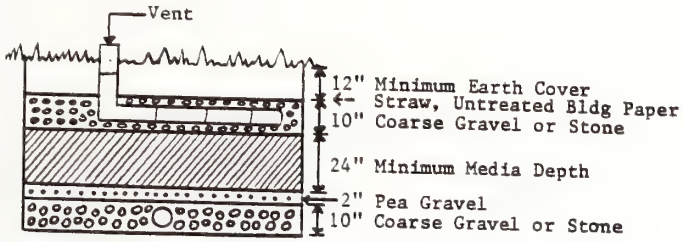
Section 905.EXHIBIT C End View



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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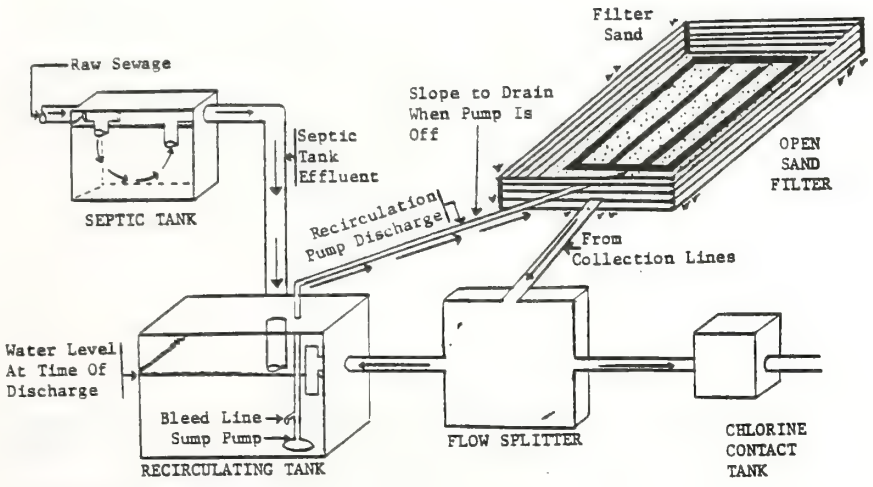
Section 905.ILLUSTRATION O Recirculating Sand Filter System

Section 905.EXHIBIT A System Diagram



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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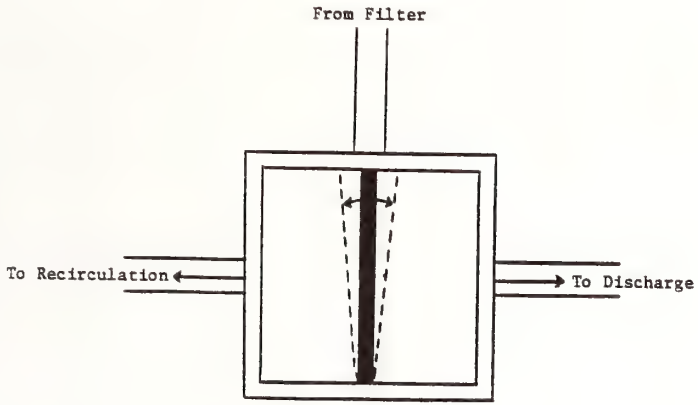
Section 905.EXHIBIT B Flow Splitter Detail



FLOW SPLITTER DETAIL

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section ILLUSTRATION P Recirculating Sand Filter Sizing Chart

NUMBER OF BEDROOMS	SEWAGE FLOW PER DAY (Gal.)	SEPTIC TANK SIZE (Gal.) No Garbage Grinder	RECIRCULATION TANK SIZE (Gal.)	AREA OF SAND FILTER (Sq.ft.)	RECOMMENDED SIZED OF SAND FILTER	NUMBER OF UNDERDRAINS	NUMBER OF DISTRIBUTION PIPES
1	200	750	500	100	10'x10'	1	3
2	400	750	500	133	11'x12'	1	3
3	600	1,000	500	200	14'x14'	1	4
4	800	1,250	500	266	16'x17'	1	5
5	1,000	1,500	500	333	18'x19'	2	6
6	1,200	1,750	500	400	20'x20'	2	6
7	1,400	2,000	500	466	20'x23'	2	6
8	1,500	2,250	500	500	20'x25'	2	6

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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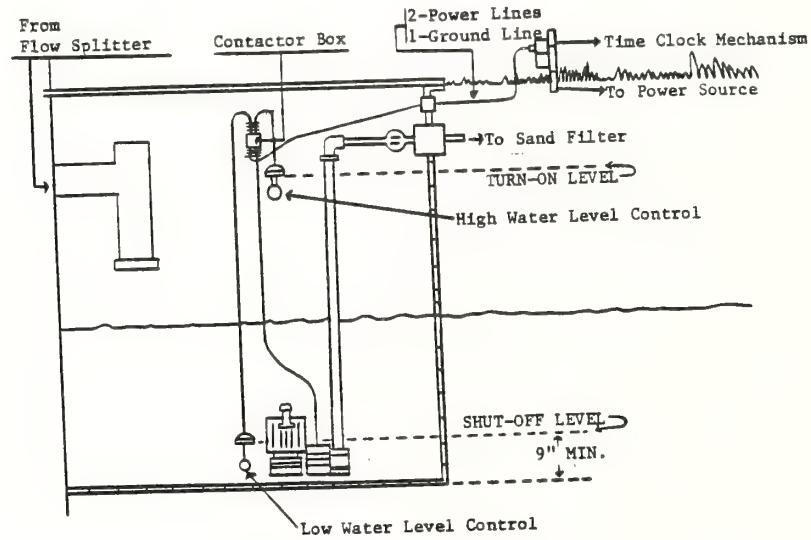
Section 905.ILLUSTRATION Q Recirculating Tank Pump Control



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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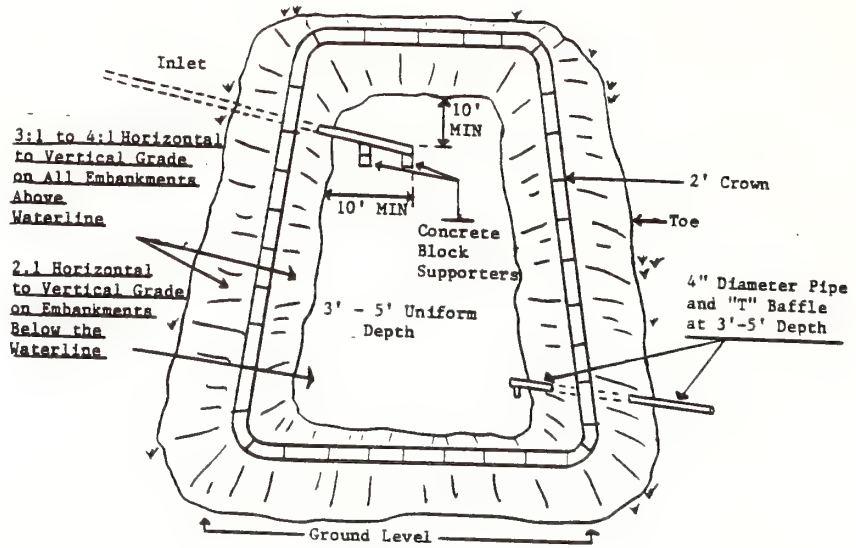
Section 905.ILLUSTRATION R Waste Stabilization Pond

Section 905.EXHIBIT A Plan View



PLAN VIEW

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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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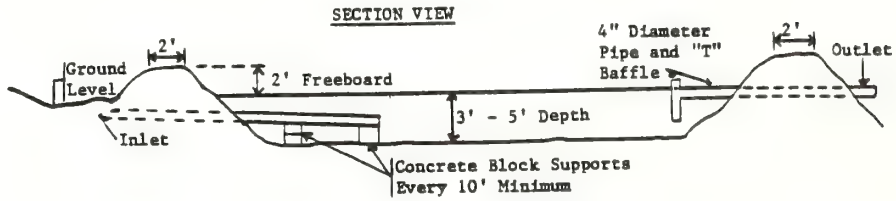
Section 905.EXHIBIT B Section View



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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Section 905.EXHIBIT C Waste Stabilization Pond Surface Area in Square Feet

	With Septic Tank			With Aeration		
Bedrooms	Depth - 3 ft.	4 ft.	5 ft.	3 ft.	4 ft.	5 ft.
1	533 1/3	400	320	160	120	96
2	1067	800	640	320	240	192
3	1600	1200	960	480	360	288
4	2133	1600	1280	640	480	384
5	2667	2000	1600	800	600	480
6	3200	2400	1920	960	720	576
7	3733	2800	2240	1120	840	672

(Source: Added at 19 Ill. Reg. _____, effective _____)

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Section 905.ILLUSTRATION S Chlorine Contact Tank

Section 905.EXHIBIT A Minimum Required Chlorine Contact Tank Volume

AVERAGE FLOW RATE GPD	MINIMUM REQUIRED VOLUME GALLONS
100	30
200	30
300	30
400	30
500	30
600	30
700	36
800	42
900	47
1000	52
1100	57
1200	63
1300	68
1400	73
1500	78

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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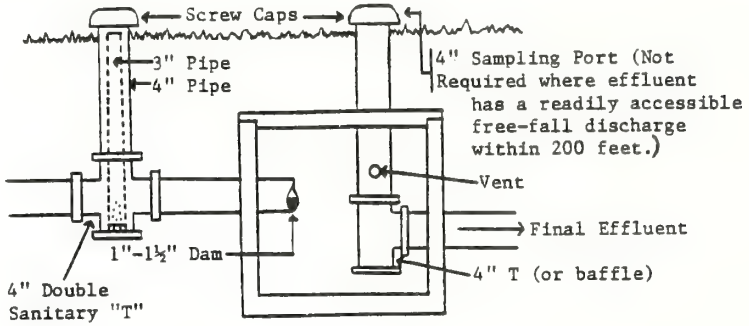
Section 905.EXHIBIT B Chlorine Feeder, Contact Tank, and Sampling Port



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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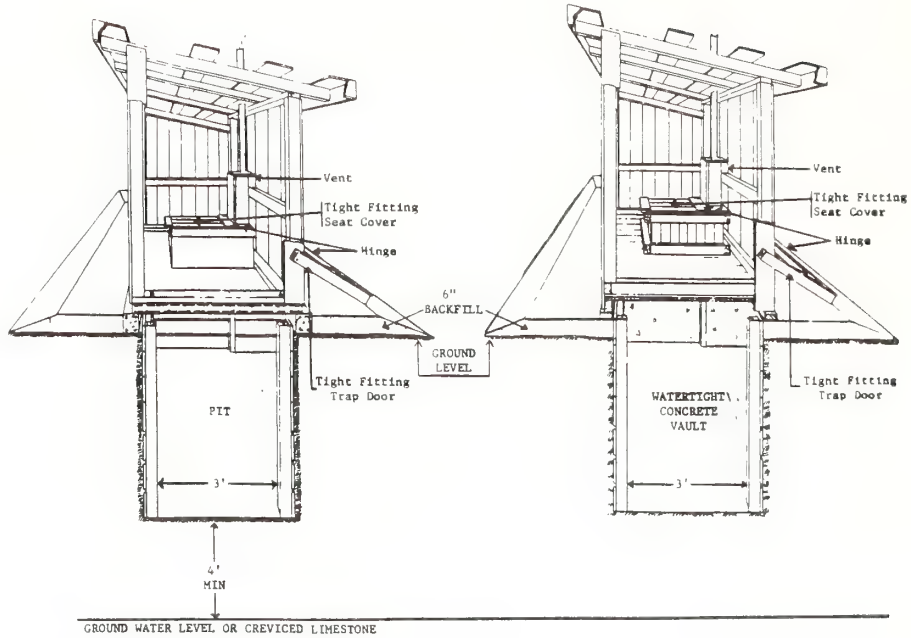
Section 905.ILLUSTRATION T Sanitary and Concrete Vault Privy



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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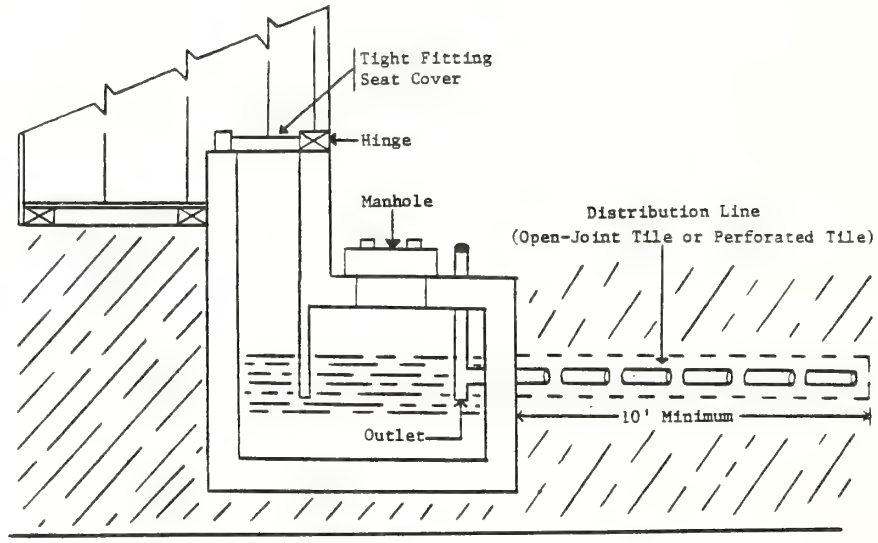
Section 905.ILLUSTRATION U Septic Privy Distribution System

Section 905.EXHIBIT A Plan View



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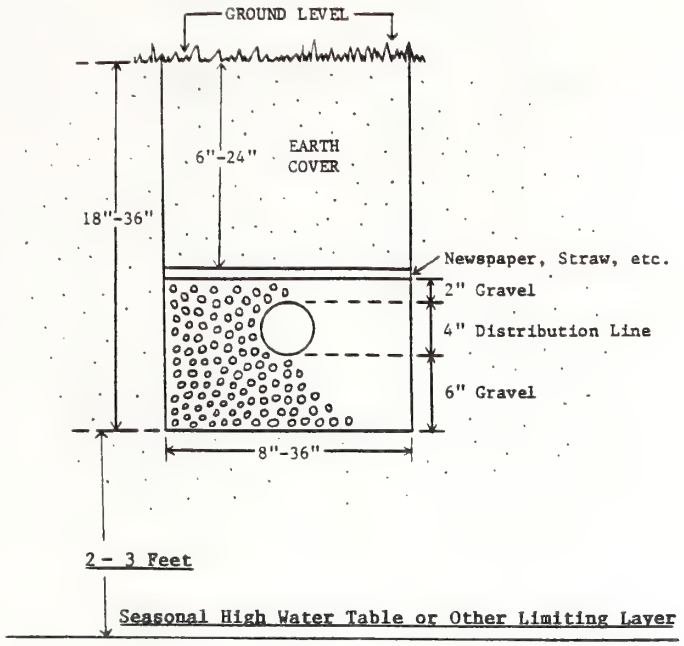
(Source: Amended at 19 Ill. Reg. _____, effective _____)

Section 905.EXHIBIT B Section View



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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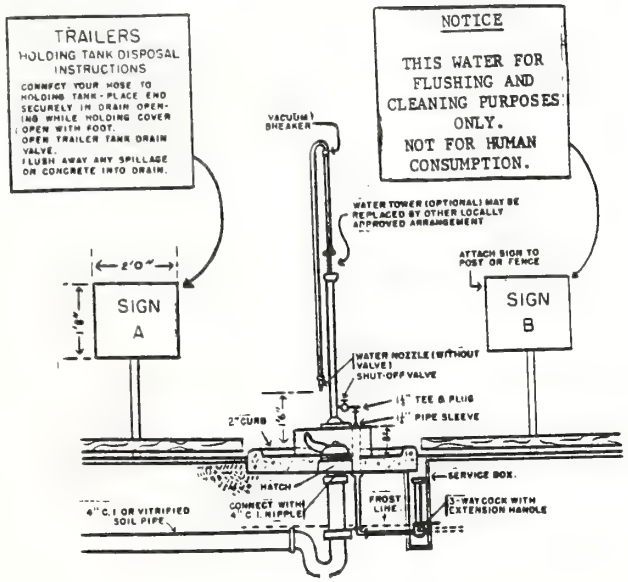
Section 905.ILLUSTRATION V Sanitary Dump Station

Section 905.EXHIBIT A Section View #1



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NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 19 Ill. Reg. _____, effective _____)

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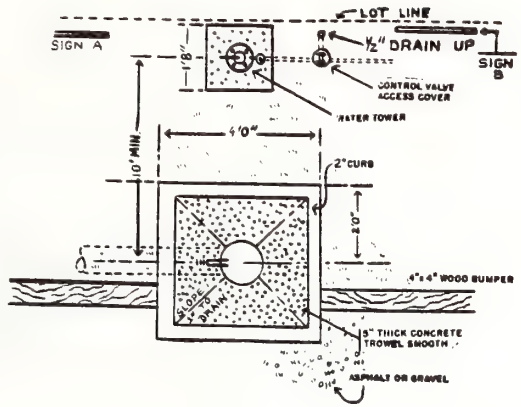
Section 905.EXHIBIT B Plan View



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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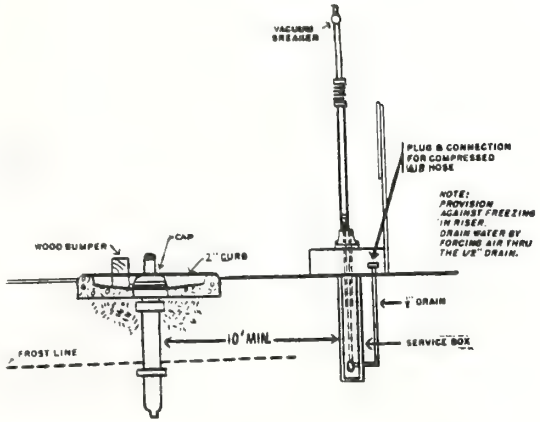
Section 905.EXHIBIT C Section View #2



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(Source: Amended at 19 Ill. Reg. _____, effective _____)

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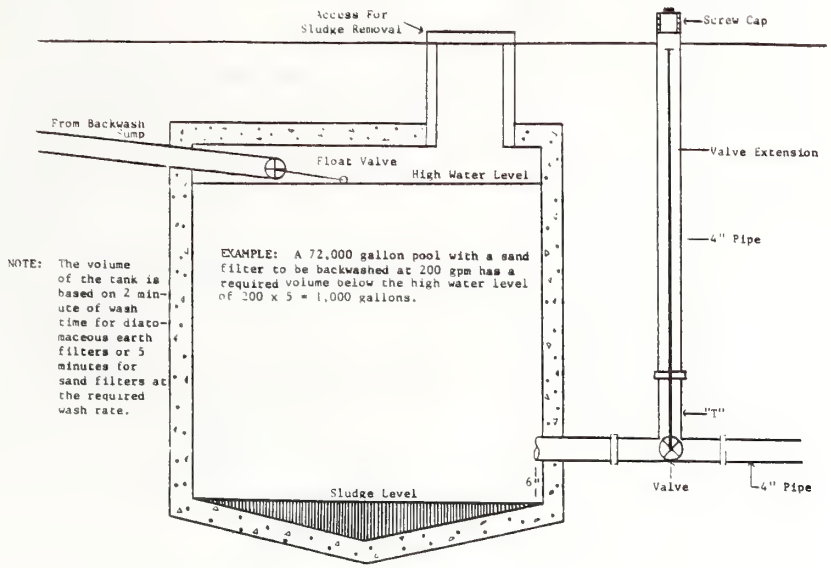
Section 905.ILLUSTRATION W Swimming Pool Backwash Water Holding Tank



DEPARTMENT OF PUBLIC HEALTH

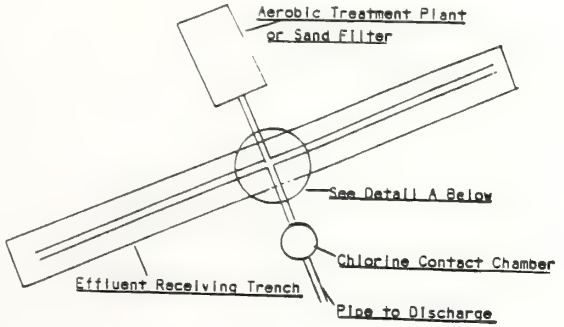
NOTICE OF PROPOSED AMENDMENTS

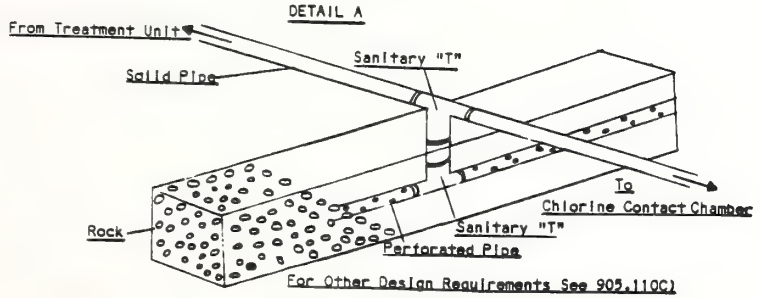
(Source: Amended at 19 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

Section 905.ILLUSTRATION X Effluent Receiving Trench ~~Local--Authorities (Repealed~~





DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

(Source: Section Repealed at 9 Ill. Reg. 20738, effective January 3, 1986; New Section added at 19 Ill. Reg. _____, effective _____)

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Property Tax Code

2) Code Citation: 86 Ill. Adm. Code 110

3) Section Numbers: Proposed Action:

110.190	Amendment
110.192	New Section

4) Statutory Authority: 35 ILCS 200/18-245 and 35 ILCS 220/18-249

5) A Complete Description of the Subjects and Issues Involved: Effective February 12, 1995, Public Act 89-1 revised the Property Tax Extension Limitation Law to expand it into Cook County. That Public Act also created the One-Year Property Tax Extension Limitation Law. Since the amendatory Act is effective immediately, it must be implemented immediately by assessors.

6) Will this proposed rule replace an emergency rule currently in effect? Yes

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? Yes

Section Numbers	Proposed Action	IL Register Citation
110.195	New Section	3/3/95, 19 Ill. Reg. 2476

10) Statement of Statewide Policy Objectives: This rulemaking does not impose a state mandate, nor does it affect any existing state mandates.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rule may submit them in writing by no later than 45 days after publication of this notice to:

Jerry Lanter
Senior Counsel - Property Tax
Illinois Department of Revenue
Office of General Counsel
101 West Jefferson
Springfield, Illinois 62708
Phone: (217) 782-6336

12) Initial Regulatory Flexibility Analysis:

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENTS

A) Types of small businesses affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) State the reason(s) for this rulemaking if it was not included in either of the two (2) most recent regulatory agendas: The statute was not yet in its final form. The upcoming regulatory agenda will not be soon enough for this emergency situation.

The full text of the Proposed Amendment(s) is identical to the emergency rulemaking which begins on page : 3556

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Pay Plan

2) Code Citation: 80 Ill. Adm. Code 310

3) Section Numbers: Adopted Action:

310.230 Amended

4) Statutory Authority: Authorized by Section 8a(2) of the Personnel Code (Ill. Rev. Stat. 1991, ch. 127, par. 63b108a.2)[20 ILCS 415/8a(2)]

5) Effective Date of Rulemaking: March 7, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: March 7, 1995

9) Notice of Proposal Published in Illinois Register: November 14, 1994, Issue #45, 18 Ill. Reg. 16490

10) Has JCAR issued a Statement of Objections to these rules? No

11) Difference(s) between proposal and final version: None

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will this rulemaking replace an emergency rule currently in effect? Yes

14) Are there any amendments pending on this Part? Yes

Section Numbers	Adopted Action	Illinois Register Citation
Appendix A		
Table L	Amended	19 Ill. Reg. 764 (January 27, 1995)
310.230	Amended	19 Ill. Reg. ___ (March ____, 1995)
310.290	Amended	19 Ill. Reg. ___ (March ____, 1995)

15) Summary and Purpose of Rulemaking: In Section 310.230, Part-Time Daily or Hourly Special Services Rate, the Department of Transportation requested that the maximum rate of the Laborer (Maintenance) be increased from $5.50 to $5.70 per hour. The Department of Transportation uses this title to hire summer students to work on the highways.

16) Information and questions regarding this adopted amendment shall be directed to:

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Mr. Michael Murphy
Department of Central Management Services
Division of Technical Services
504 William G. Stratton Building
Springfield, IL 62706
(217) 782-5601

17) State reasons for this rulemaking if it was not included in the two (2) most recent regulatory agendas:

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES
SUBTITLE B: PERSONNEL RULES, PAY PLANS, AND POSITION CLASSIFICATIONS
CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

PART 310
PAY PLAN

SUBPART A: NARRATIVE

Section
310.20 Policy and Responsibilities
310.30 Jurisdiction
310.40 Pay Schedules
310.50 Definitions
310.60 Conversion of Base Salary to Pay Period Units
310.70 Conversion of Base Salary to Daily or Hourly Equivalents
310.80 Increases in Pay
310.90 Decreases in Pay
310.100 Other Pay Provisions
310.110 Implementation of Pay Plan Changes for Fiscal Year 1995
310.120 Interpretation and Application of Pay Plan
310.130 Effective Date
310.140 Reinstitution of Within Grade Salary Increases
310.150 Fiscal Year 1985 Pay Changes in Schedule of Salary Grades, Effective July 1, 1984 (Repealed)

SUBPART B: SCHEDULE OF RATES

Section
310.205 Introduction
310.210 Prevailing Rate
310.220 Negotiated Rate
310.230 Part-Time Daily or Hourly Special Services Rate
310.240 Hourly Rate
310.250 Member, Patient and Inmate Rate
310.260 Trainee Rate
310.270 Legislated and Contracted Rate
310.280 Designated Rate
310.290 Out-of-State or Foreign Service Rate
310.300 Educator Schedule for RC-063 and HR-010
310.310 Physician Specialist Rate
310.320 Annual Compensation Ranges for Executive Director and Assistant Executive Director, State Board of Elections
310.330 Excluded Classes Rate (Repealed)

SUBPART C: MERIT COMPENSATION SYSTEM

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

Section
310.410 Jurisdiction
310.420 Objectives
310.430 Responsibilities
310.440 Merit Compensation Salary Schedule
310.450 Procedures for Determining Annual Merit Increases
310.455 Intermittent Merit Increase
310.456 Merit Zone
310.460 Other Pay Increases
310.470 Adjustment
310.480 Decreases in Pay
310.490 Other Pay Provisions
310.495 Public Service Administrator Class Series
310.500 Definitions
310.510 Conversion of Base Salary to Pay Period Units
310.520 Conversion of Base Salary to Daily or Hourly Equivalents
310.530 Implementation
310.540 Annual Merit Increase Guidechart for Fiscal Year 1995
310.550 Fiscal Year 1985 Pay Changes in Merit Compensation System, effective July 1, 1984 (Repealed)

APPENDIX A Negotiated Rates of Pay
TABLE A HR-190 (Department of Central Management Services - State of Illinois Building - SEIU)
TABLE B HR-200 (Department of Labor - Chicago, Illinois - SEIU)
TABLE C RC-069 (Firefighters, AFSCME)
TABLE D HR-001 (Teamsters Local #726)
TABLE E RC-020 (Teamsters Local #330)
TABLE F RC-019 (Teamsters Local #25)
TABLE G RC-045 (Automotive Mechanics, IFPE)
TABLE H RC-006 (Corrections Employees, AFSCME)
TABLE I RC-009 (Institutional Employees, AFSCME)
TABLE J RC-014 (Clerical Employees, AFSCME)
TABLE K RC-023 (Registered Nurses, INA)
TABLE L VR-004 (Illinois State Treasurer's Office Employees, Teamsters and IFT)
TABLE M RC-110 (Conservation Police Lodge)
TABLE N RC-010 (Professional Legal Unit, AFSCME)
TABLE O RC-028 (Paraprofessional Human Services Employees, AFSCME)
TABLE P RC-029 (Paraprofessional Investigatory and Law Enforcement Employees, IFPE)
TABLE Q RC-033 (Meat Inspectors, IFPE)
TABLE R RC-042 (Residual Maintenance Workers, AFSCME)
TABLE S HR-012 (Fair Employment Practices Employees, SEIU)
TABLE T HR-010 (Teachers of Deaf, IFT)
TABLE U HR-010 (Teachers of Deaf, Extracurricular Paid Activities)
TABLE V CU-500 (Corrections, Meet and Confer Employees)
TABLE W RC-062 (Technical Employees, AFSCME)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

TABLE X	RC-063 (Professional Employees, AFSCME)
TABLE Y	RC-063 (Educators, AFSCME)
TABLE Z	RC-063 (Physicians, AFSCME)
APPENDIX B	Schedule of Salary Grades - Monthly and Annual Rates of Pay for Fiscal Year 1995
APPENDIX C	Medical Administrator Rates for Fiscal Year 1995
APPENDIX D	Merit Compensation System Salary Schedule for Fiscal Year 1995
APPENDIX E	Teaching Salary Schedule (Repealed)
APPENDIX F	Physician and Physician Specialist Salary Schedule (Repealed)
APPENDIX G	Public Service Administrator Class Series Salary Schedule

AUTHORITY: Implementing and authorized by Section 8a(2) of the Personnel Code [20 ILCS 415/8a(2)].

SOURCE: Filed June 28, 1967; codified at 8 Ill. Reg. 1558; emergency amendment at 8 Ill. Reg. 1990, effective January 31, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 2440, effective February 15, 1984; emergency amendment at 8 Ill. Reg. 3348, effective March 5, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 4249, effective March 16, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 5704, effective April 16, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 7290, effective May 11, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 11299, effective June 25, 1984; emergency amendment at 8 Ill. Reg. 12616, effective July 1, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 15007, effective August 6, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 15367, effective August 13, 1984; emergency amendment at 8 Ill. Reg. 21310, effective October 10, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 21544, effective October 24, 1984; amended at 8 Ill. Reg. 22844, effective November 14, 1984; emergency amendment at 9 Ill. Reg. 1134, effective January 16, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 1320, effective January 23, 1985; amended at 9 Ill. Reg. 3681, effective March 12, 1985; emergency amendment at 9 Ill. Reg. 4163, effective March 15, 1985, for a maximum of 150 days; emergency amendment at 9 Ill. Reg. 9231, effective May 31, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 9420, effective June 7, 1985; amended at 9 Ill. Reg. 10663, effective July 1, 1985; emergency amendment at 9 Ill. Reg 15043, effective September 24, 1985, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 3325, effective January 22, 1986; amended at 10 Ill. Reg. 3230, effective January 24, 1986; emergency amendment at 10 Ill. Reg. 8904, effective May 13, 1986, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 8928, effective May 13, 1986; emergency amendment at 10 Ill. Reg. 12090, effective June 30, 1986, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 13675, effective July 31, 1986; peremptory amendment at 10 Ill. Reg. 14867, effective August 26, 1986; amended at 10 Ill. Reg. 15567, effective September 17, 1986; emergency amendment at 10 Ill. Reg. 17765, effective September 30, 1986, for a maximum of 150 days; peremptory amendment at 10 Ill. Reg. 19132, effective October 28, 1986; peremptory amendment at 10 Ill. Reg. 21097, effective December 9, 1986; amended at 11 Ill. Reg. 648, effective December 22, 1986; peremptory amendment at 11 Ill. Reg. 3363, effective February 3, 1987; peremptory amendment at 11 Ill. Reg. 4388, effective February 27, 1987; peremptory amendment at 11 Ill. Reg. 6291, effective March 23, 1987; amended at 11 Ill. Reg. 5901, effective March 24, 1987; emergency amendment at 11 Ill. Reg. 8787, effective April 15, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 11830, effective July 1, 1987, for a maximum of 150 days; peremptory amendment at 11 Ill. Reg. 13675, effective July 29, 1987; amended at 11 Ill. Reg. 14984, effective August 27, 1987; peremptory amendment at 11 Ill. Reg. 15273, effective September 1, 1987; peremptory amendment 11 Ill. Reg. 17919, effective October 19, 1987; peremptory amendment at 11 Ill. Reg. 19812, effective November 19, 1987; emergency amendment at 11 Ill. Reg. 20664, effective December 4, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 20778, effective December 11, 1987; peremptory amendment at 12 Ill. Reg. 3811, effective January 27, 1988; peremptory amendment at 12 Ill. Reg. 5459, effective March 3, 1988; amended at 12 Ill. Reg. 6073, effective March 21, 1988; peremptory amendment at 12 Ill. Reg. 7783, effective April 14, 1988; emergency amendment at 12 Ill. Reg. 7734, effective April 15, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 8135, effective April 22, 1988; peremptory amendment at 12 Ill. Reg. 9745, effective May 23, 1988; emergency amendment at 12 Ill. Reg. 11778, effective July 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 12895, effective July 18, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 13306, effective July 27, 1988; corrected at 12 Ill. Reg. 13359; amended at 12 Ill. Reg. 14630, effective September 6, 1988; amended at 12 Ill. Reg. 20449, effective November 28, 1988; peremptory amendment at 12 Ill. Reg. 20584, effective November 28, 1988; peremptory amendment at 13 Ill. Reg. 8849, effective May 10, 1989; amended at 13 Ill. Reg. 8080, effective May 30, 1989; peremptory amendment at 13 Ill. Reg. 8970, effective May 26, 1989; emergency amendment at 13 Ill. Reg. 10967, effective June 20, 1989, for a maximum of 150 days; emergency amendment expired on November 17, 1989; amended at 13 Ill. Reg. 11451, effective June 28, 1989; emergency amendment at 13 Ill. Reg. 11854, effective July 1, 1989, for a maximum of 150 days; corrected at 13 Ill. Reg. 12647; peremptory amendment at 13 Ill. Reg. 12887, effective July 24, 1989; amended at 13 Ill. Reg. 16950, effective October 20, 1989; amended at 13 Ill. Reg. 19221, effective December 12, 1989; amended at 14 Ill. Reg. 615, effective January 2, 1990; peremptory amendment at 14 Ill. Reg. 1627, effective January 11, 1990; amended at 14 Ill. Reg. 4455, effective March 12, 1990; peremptory amendment at 14 Ill. Reg. 7652, effective May 7, 1990; amended at 14 Ill. Reg. 10002, effective June 11, 1990; emergency amendment at 14 Ill. Reg. 11330, effective June 29, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14361, effective August 24, 1990; emergency amendment at 14 Ill. Reg. 15570, effective September 11, 1990, for a maximum of 150 days; emergency amendment expired on February 8, 1991; corrected at 14 Ill. Reg. 16092; peremptory amendment at 14 Ill. Reg. 17098, effective September 26, 1990; amended at 14 Ill. Reg. 17189, effective October 2, 1990; amended at 14 Ill. Reg. 17189, effective October 19, 1990; amended at 14 Ill. Reg. 18719, effective November 13, 1990; peremptory amendment at 14 Ill. Reg. 18854, effective November 13, 1990; peremptory amendment at 15 Ill. Reg. 663, effective January 7, 1991; amended at 15 Ill. Reg. 3296, effective February 14,

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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1991; amended at 15 Ill. Reg. 4401, effective March 11, 1991; peremptory amendment at 15 Ill. Reg. 5100, effective March 20, 1991; peremptory amendment at 15 Ill. Reg. 5465, effective April 2, 1991; emergency amendment at 15 Ill. Reg. 10485, effective July 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 11080, effective July 19, 1991; amended at 15 Ill. Reg. 13080, effective August 21, 1991; amended at 15 Ill. Reg. 14210, effective September 23, 1991; emergency amendment at 16 Ill. Reg. 711, effective December 26, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 3450, effective February 20, 1992; peremptory amendment at 16 Ill. Reg. 5068, effective March 11, 1992; peremptory amendment at 16 Ill. Reg. 7056, effective April 20, 1992; emergency amendment at 16 Ill. Reg. 8239, effective May 19, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 8382, effective May 26, 1992; emergency amendment at 16 Ill. Reg. 13950, effective August 19, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14452, effective September 4, 1992, for a maximum of 150 days; amended at 17 Ill. Reg. 238, effective December 23, 1992; peremptory amendment at 17 Ill. Reg. 498, effective December 18, 1992; amended at 17 Ill. Reg. 590, effective January 4, 1993; amended at 17 Ill. Reg. 1819, effective February 2, 1993; amended at 17 Ill. Reg. 6441, effective April 8, 1993; emergency amendment at 17 Ill. Reg. 12900, effective July 22, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 13409, effective July 29, 1993; emergency amendment at 17 Ill. Reg. 13789, effective August 9, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 14666, effective August 26, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 19103, effective October 25, 1993; emergency amendment at 17 Ill. Reg. 21858, effective December 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 22514, effective December 15, 1993; amended at 18 Ill. Reg. 227, effective December 17, 1993; amended at 18 Ill. Reg. 1107, effective January 18, 1994; amended at 18 Ill. Reg. 5146, effective March 21, 1994; peremptory amendment at 18 Ill. Reg. 9562, effective June 13, 1994; emergency amendment at 18 Ill. Reg. 11299, effective July 1, 1994, for a maximum of 150 days; peremptory amendment at 18 Ill. Reg. 13476, effective August 17, 1994; emergency amendment at 18 Ill. Reg. 14417, effective September 9, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16545, effective October 28, 1994; peremptory amendment at 18 Ill. Reg. 16708, effective October 28, 1994; amended at 18 Ill. Reg. 17191, effective November 21, 1994; amended at 19 Ill. Reg. 1024, effective January 24, 1995; amended at 19 Ill. Reg. 3456, effective MAR 07 1995.

Section 310.230 Part-Time Daily or Hourly Special Services Rate

The rate of pay as approved by the Director of Central Management Services for persons employed on a consultative or part-time basis requiring irregular hours of work shall be as listed below, except the total compensation of an employee in any given month shall not exceed the monthly rate of Step 5 of the salary grade for the title as shown in the Schedule of Salary Grades (Appendix B) of this Part if the class title is subject to the Schedule of Salary Grades, or Step 5 of the negotiated salary range for classes of positions shown in Section 310.220, Subpart B, Schedule of Rates, or 75% of the maximum rate of those

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED AMENDMENTS

classes of positions subject to the provisions of the Merit Compensation System, Subpart C of this Pay Plan.

Account Technician II	11.00 to 14.08 (hourly) 83 to 106 (daily)
Apiary Inspector	32 to 50
Building/Grounds Laborer	4.25 to 6.00 (per hour)
Building/Grounds Lead I	4.25 to 7.00 (per hour)
Building/Grounds Lead II	5.25 to 8.00 (per hour)
Building/Grounds Maintenance Worker	5.00 to 6.00 (per hour)
Chaplain I	32 to 70
Chemist I	32 to 45
Conservation/Historic Preservation Worker	4.50 (per hour)
Conservation/Historic Preservation Worker (2nd season -- site interpretation)	4.64 (per hour)
Conservation/Historic Preservation Worker (3rd season -- site interpretation)	4.78 (per hour)
Dentist I	70 to 150
Dentist II	100 to 185
Educator	32 to 60
Educator Aide	32 to 35
Guard II	67 to 84
Guard III	75 to 96
Hearing and Speech Coordinator	15 to 30 (per hour)
Hearings Referee	75 to 200
Janitor I	4.73 to 5.30 (per hour)
Labor Maintenance Lead Worker	5.00 to 6.00 (per hour)
Labor Relations Investigator	35 to 70
Laborer (Maintenance)	4.25 to ~~5.50~~ $5.70 (per hour)
Maintenance Worker	4.25 to 5.00 (per hour)
Occupational Therapist Program Coordinator	40 to 160
Office Aid	4.25 to 9.34 (hourly) 42 to 70 (daily)
Office Assistant	4.25 to 10.78 (hourly) 42 to 81 (daily)
Office Associate	4.25 to 11.71 (hourly) 42 to 88 (daily)
Office Clerk	4.25 to 10.01 (hourly) 61 to 75 (daily)
Optometrist	50 to 160 (daily)
Optometrist	15 to 35 (hourly)
Physician	100 to 300
Physician Specialist (A)	100 to 325 (daily)
Physician Specialist (A)	20 to 60 (hourly)

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Physician Specialist (B)	100 to 350 (daily)
Physician Specialist (B)	20 to 70 (hourly)
Physician Specialist (C)	100 to 360 (daily)
Physician Specialist (C)	20 to 75 (hourly)
Physician Specialist (D)	100 to 370 (daily)
Physician Specialist (D)	20 to 85 (hourly)
Podiatrist	50 to 125
Psychologist I	35 to 80
Psychologist II	40 to 125
Psychologist III	40 to 150
Recreation Worker I	32 to 40
Recreation Worker I	5.33 (per hour)
Registered Nurse I	39 to 54
Registered Nurse I (2nd or 3rd shift)	41 to 56
Registered Nurse I (Cook County)	43 to 58
Registered Nurse I (Cook County - 2nd or 3rd shift)	44 to 59
Registered Nurse II	43 to 58
Registered Nurse II (2nd or 3rd shift)	44 to 59
Registered Nurse II (Cook County)	45 to 60
Registered Nurse II (Cook County - 2nd or 3rd shift)	47 to 62
Social Worker II	35 to 75
Social Worker III	35 to 80
Student Worker	4.25 to 8.00 (per hour)
Tax Examiner	9.69 to 12.21 (hourly)
	73 to 92 (daily)
Technical Advisor II	32 to 35 (per hour)
Technical Advisor III	32 to 60 (per hour)
Technical Advisor IV	50 to 80 (per hour)
Veterinarian II	95 to 130 (daily)

(Source: Amended at 19 Ill. Reg. 3456, effective MAR 07 1995)

CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Appeal of Child Abuse and Neglect Investigation Findings

2) Code Citation: 89 Ill. Adm. Code 336

3) Section Numbers: Adopted Action:

336.150 Amendment

4) Statutory Authority: [325 ILCS 5/7.16]

5) Effective Date of Rulemaking: March 1, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No.

8) Date Filed in Agency's Principal Office: March 1, 1995

9) Notice of Proposal Published in Illinois Register: July 22, 1994; 18 Ill. Reg. 11407

10) Has JCAR issued a Statement of Objections to these rules? No

11) Difference(s) between proposal and final version: With the exception of some corrections in the statutory citations and some minor editing corrections, no changes were made.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will this rulemaking replace an emergency rule currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Rulemaking: The amendments differentiate between persons who receive notice of the final administrative decision when indicated reports of child abuse or neglect findings are appealed by the perpetrator. The first group receives notice of all final administrative decisions because they are in a position to affect the employment or licensure of the appellant and will base their decision on the outcome of the appeal. The second group receives notice only when the final administrative decision reverses or changes the indicated finding.

16) Information and questions regarding this adopted amendment shall be directed to:

Jacqueline Nottingham, Chief

CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

Office of Rules and Procedures
Department of Children and Family Services
406 East Monroe Street, Station #222
Springfield, IL 62701-1498
(217) 524-1983; TTY: (217) 524-3715

17) State reasons for this rulemaking if it was not included in the two (2) most recent regulatory agendas:

The full text of the Adopted Amendment begins on the next page:

CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER III: DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SUBCHAPTER b: PROGRAM AND TECHNICAL SUPPORT

PART 336
APPEAL OF CHILD ABUSE AND NEGLECT
INVESTIGATION FINDINGS

Section
336.10 Purpose
336.20 Definitions
336.30 Who May Appeal
336.40 What May Be Appealed
336.50 What May Not Be Appealed
336.60 The Right to Appeal and Receive a Fair Hearing
336.70 Notices of Department Decisions
336.80 The Appeal Process
336.90 Child Protection Internal Review
336.100 Notice of Internal Review Decision
336.110 The Administrative Hearing
336.120 Rights and Responsibilities in Administrative Hearings
336.130 The Administrative Law Judge
336.140 Combined or Separate Hearings
336.150 Final Administrative Decision
336.160 Records of Administrative Hearings
336.170 Severability of This Part

AUTHORITY: Authorized by Section 5 of the Children and Family Services Act [20 ILCS 505/5]; implementing Section 7.16 of the Abused and Neglected Child Reporting Act (Ill. Rev. Stat. 1991, ch. 23, par. 2057.16) [325 ILCS 5/7.16].

SOURCE: Adopted at 17 Ill. Reg. 1026, effective January 15, 1993; amended at 19 Ill. Reg. 3465 1, effective MAR 0 1 1995.

Section 336.150 Final Administrative Decision

a) Making the Final Administrative Decision
The Director of the Department shall receive the recommended decision from the administrative law judge and shall agree, disagree, or modify the recommended decision based upon the credible evidence standard. The Director's decision is the final administrative decision of the Department. If the decision requires corrective action by the Department, the Director shall appoint a Department staff person who shall be responsible for assuring compliance with the decision.

b) Notice of the Availability of Judicial Review
The Department shall include a notice to appellants as part of the final administrative decision. This notice shall include the name of the person responsible for compliance, if applicable, and shall advise

CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

the appellants that, under the provisions of the Administrative Review Law ~~[Ill.--Rev.--Stat.--1991,--ch.--110,-par.-3-101-et-seq.]~~ [735 ILCS ~~5/3-101~~ 5/Art. III], they may seek judicial review of the Department's decisions if it is unfavorable to them, within the statutory time frame.

c) Who Receives Copies of the Final Administrative Decision
The appellant or authorized representative, the Department child protection investigation unit, the Department's representative, the administrative law judge (except for notices of internal review decisions), the Administrator of the Administrative Hearing Unit, and the State Central Register shall receive a copy of the final administrative decision.

d) Notifying Others of the Decision
1) The following persons shall receive a notice of the final administrative decision:
~~1) parents or personal guardians of the child victim(s) if they are not the same as the appellant;~~
~~2) the mandated reporter who originally made the report of child abuse or neglect;~~
~~3) the juvenile court judge and guardian ad litem (when a state ward is involved);~~
A) ~~4)~~ the Illinois Department of Professional Regulation, district, regional and private school superintendents and the State Board of Education when they have been notified that an appeal has been filed in accordance with 89 Ill. Adm. Code 300, Reports of Child Abuse and Neglect, Section 300.140;
B) ~~5)~~ administrators of child care facilities and Department licensing staff when the appellant is an employee of a child care facility; and
C) ~~6)~~ supervisors or administrators notified in accordance with 89 Ill. Adm. Code 300.100(i).
2) The following persons shall receive a notice of the final administrative decision, if the decision amends, expunges or removes any record made under Section 7.17 of the Abused and Neglected Child Reporting Act 1991 [325 ILCS 5/7.17]:
A) parents or personal guardians of the child victim(s) if they are not the same as the appellant;
B) the mandated reporter who originally made the report of child abuse or neglect; and
C) the juvenile court judge and guardian ad litem (when a State ward is involved).

(Source: Amended at 19 Ill. Reg. 3465, effective MAR 01 1995)

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1) Heading of the Part: Reports of Child Abuse and Neglect

2) Code Citation: 89 Ill. Adm. Code 300

3) Section Numbers: Adopted Action:

300 Appendix B Amendment

4) Statutory Authority: [325 ILCS 5/1]

5) Effective Date of Rulemaking: March 15, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: March 15, 1995

9) Notice of Proposal Published in Illinois Register:

June 3, 1994 18 Ill. Reg. 8240

10) Has JCAR issued a Statement of Objections to these rules? No

11) Difference(s) between proposal and final version:

In the Source note after "150 days" add "emergency expired on February 7, 1994"; "after May 31, 1994;" add "amended at 18 Ill. Reg. 8601, effective June 1, 1994;"

Under Allegation "15/65 Substance Misuse", after "meconium" add in parentheses "newborn's first stool"; delete the Illinois Revised Statutes citation.

Under Allegation "18, Sexually Transmitted Diseases", Correct the spelling of the words "Inguinale" and "Ducreyi".

Under Allegation "74, Inadequate Supervision", in the first paragraph under 1) Child Factors, delete the comma and the word "and" after "emergency" and add a period; in the fourth paragraph delete the comma after "restricted"; under "3) Incident Factors", rewrite the seventh paragraph to read "whether food and other provisions were left for the child"; in the next paragraph change the "o" in "Other" to lower case and delete the period after "child".

Under Allegation "79, Medical Neglect, B. Immunizations" add "the" before "Communicable" and delete the reference to the Illinois Revised Statutes.

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In addition, there were many other minor editing changes consisting primarily of punctuation corrections.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will this rulemaking replace an emergency rule currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Rulemaking:
Section 300.Appendix B has been amended to include revisions to the definitions of Substance Misuse, Sexually Transmitted Diseases, and Inadequate Supervision necessitated by Public Acts 88-167 and 88-479.

16) Information and questions regarding this adopted amendment shall be directed to:

Name: Jacqueline Nottingham, Chief
Address: Office of Rules and Procedures
Department of Children and Family Services
406 East Monroe St., Station # 222
Springfield, Illinois 62701-1498
Telephone: (217)524-1983
TTY: (217)524-3715

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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TITLE 89: SOCIAL SERVICES
CHAPTER III: DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SUBCHAPTER a: SERVICE DELIVERY

PART 300
REPORTS OF CHILD ABUSE AND NEGLECT

Section
300.10 Purpose
300.20 Definitions
300.30 Reporting Child Abuse or Neglect to the Department
300.40 Content of Child Abuse or Neglect Reports
300.50 Transmittal of Child Abuse or Neglect Reports
300.60 Special Types of Reports (Recodified)
300.70 Referrals to the Local Law Enforcement Agency and State's Attorney
300.80 Delegation of the Investigation
300.90 Time Frames for the Investigation
300.100 Initial Investigation
300.110 The Formal Investigative Process
300.120 Taking Children into Temporary Protective Custody
300.130 Notices Whether Child Abuse or Neglect Occurred
300.140 Transmittal of Information to the Illinois Department of Professional Regulation and to School Superintendents
300.150 Referral for Other Services
300.160 Special Types of Reports
APPENDIX A Acknowledgement of Mandated Reporter Status
APPENDIX B Child Abuse and Neglect Allegations

AUTHORITY: Implementing and authorized by the Abused and Neglected Child Reporting Act (Ill. Rev. Stat. 1991, ch. 23, pars. 2051 et seq.) [325 ILCS 5] and Section 3 of the Consent by Minors to Medical Procedures Act (Ill. Rev. Stat. 1991, ch. 111, par. 4503) [410 ILCS 210/3].

SOURCE: Adopted and codified as 89 Ill. Adm. Code 302 at 5 Ill. Reg. 13188, effective November 30, 1981; amended at 6 Ill. Reg. 15529, effective January 1, 1983; recodified at 8 Ill. Reg. 992; peremptory amendment at 8 Ill. Reg. 5373, effective April 12, 1984; amended at 8 Ill. Reg. 12143, effective July 9, 1984; amended at 9 Ill. Reg. 2467, effective March 1, 1985; amended at 9 Ill. Reg. 9104, effective June 14, 1985; amended at 9 Ill. Reg. 15820, effective November 1, 1985; amended at 10 Ill. Reg. 5915, effective April 15, 1986; amended at 11 Ill. Reg. 1390, effective January 13, 1987; amended at 11 Ill. Reg. 1151, effective January 14, 1987; amended at 11 Ill. Reg. 1829, effective January 15, 1987; recodified from 89 Ill. Adm. Code 302.20, 302.100, 302.110, 302.120, 302.130, 302.140, 302.150, 302.160, 302.170, 302.180, 302.190, and Appendix A at 11 Ill. Reg. 3492; emergency amendments at 11 Ill. Reg. 4058, effective February 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 12619, effective July 20, 1987; recodified at 11 Ill. Reg. 13405; amended at 13 Ill. Reg. 2419, effective March 1, 1989; emergency amendment at 14 Ill. Reg. 11356,

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effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 17558, effective October 15, 1990; amended at 14 Ill. Reg. 19827, effective November 28, 1990; emergency amendment at 15 Ill. Reg. 14285, effective September 25, 1991; amended at 15 Ill. Reg. 17986, effective December 1, 1991; emergency amendment at 17 Ill. Reg. 15698, effective September 10, 1993, for a maximum of 150 days; emergency expired February 7, 1994; amended at 18 Ill. Reg. 8377, effective May 31, 1994; amended at 18 Ill. Reg. 8601, effective June 1, 1994; amended at 19 Ill. Reg. 3469, effective MAR 15 1995.

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Section 300.APPENDIX B Child Abuse and Neglect Allegations

This Appendix describes the specific incidents of harm which must be alleged to have been caused by the acts or omissions of the persons identified in Section 3 of the Abused and Neglected Child Reporting Act before the Department will accept a report of child abuse or neglect. The allegation definitions focus upon the harm or the risk of harm to the child. Many of the allegations of harm can be categorized as resulting from either abuse or neglect. All abuse allegations of harm are coded with a one or two digit number under thirty. All neglect allegations of harm are coded with a two digit number greater than fifty. In addition each allegation is coded with a priority number, either I, II or III. This priority number ranges from the most serious, Level I, to the least serious, Level III. The allegations of harm, with their assigned priority number in parenthesis, are defined as follows:

Allegation #	Definition
1/51	Death (Priority I)

Permanent cessation of all vital functions.

The following definitions of death are also commonly used:

- Total irreversible cessation of cerebral function, spontaneous function of the respiratory system, and spontaneous function of the circulatory system.
- The final and irreversible cessation of perceptible heart beat and respiration.

Verification of death must come from a physician or coroner.

2/52 Brain Damage/Skull Fracture (Priority I)

Brain damage means injury to the large, soft mass of nerve tissue contained within the cranium skull. Skull fracture means a broken bone in the skull.

Verification of brain damage or skull fracture must come from a physician, preferably a neurosurgeon or radiologist.

3/53 Subdural Hematoma (Priority I)

Hematoma

A swelling or mass of blood (usually clotted) confined to an organ, tissue or space and caused by a break in a blood vessel.

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Allegation #	Definition
	Subdural Beneath the dura mater (the outer membrane covering the spinal cord and brain). A subdural hematoma is located beneath the membrane covering the brain and is usually the result of head injuries or the shaking of a small child or infant. It may result in loss of consciousness, seizures, mental or physical damage, or death. Verification of subdural hematoma must come from a physician.
4/54	Internal Injuries (Priority I) An internal injury is an injury which is not visible from the outside, e.g. an injury to the organs occupying the thoracic or abdominal cavities. Such injury may result from a direct blow. A person so injured may be pale, cold, perspiring freely, have an anxious expression, or may seem semicomatose. Pain is usually intense at first, and may continue or gradually diminish as patient grows worse. Verification of internal injuries must come from a physician.
5/55	Burns/Scalding (Priority II) Burns Tissue injury resulting from excessive exposure to thermal, chemical, electrical or radioactive agents. The effects vary according to the type, duration and intensity of the agent and the part of the body involved. Burns are usually classified as: - First Degree Superficial burns, damage being limited to the outer layer of skin. Scorching or painful redness of the skin. - Second Degree

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Allegation #	Definition
	The damage extends through the outer layer of the skin into the inner layers. Blistering will be present within 24 hours. - Third Degree Burns in which the skin is destroyed with damage extending into underlying tissues, which may be charred or coagulated. Scalding A burn to the skin or flesh caused by moist heat and hot vapors, as steam. All emersion burns (scalds) must be confirmed by a physician unless the alleged perpetrator has admitted to scalding the child.
6/56	Poison/Noxious Substances (Priority II) Poison Any substance, other than mood altering chemicals or alcohol, taken into the body by ingestion, inhalation, injection, or absorption that interferes with normal physiological functions. (Virtually any substance can be poisonous if consumed in sufficient quantity; therefore, the term poison more often implies an excessive amount rather than a specific group of substances.) Noxious Harmful, injurious, not wholesome. Verification must come from a physician or by a direct admission from the alleged perpetrator.
7/57	Wounds (Priority I) A gunshot or stabbing injury. Verification must come from a physician, a law enforcement officer or by a direct admission from the alleged perpetrator.

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Allegation #	Definition
8	No allegation.
9 59	Bone Fractures (Priority II) A fracture is a broken bone. There are ten types of fractures, the most common being: Chip Fracture A small piece of bone is flaked from the major part of the bone. Simple Fracture The bone is broken, but there is no external wound. Complicated Fractures Compound The bone is broken, and there is an external wound leading down to the site of fracture or fragments of bone protrude through the skin. Comminuted The bone is broken or splintered into pieces. Spiral Twisting causes the line of the fracture to encircle the bone in the form of a spiral. Verification must come from a physician or radiologist.
10	No allegation.
11/61	Cuts, Bruises and Welts (Priority II) Cut An opening, incision or break in the skin made by some external agent. Bruise An injury which results in bleeding within the skin, where the skin is discolored but not broken. Welt

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Allegation #	Definition
	An elevation on the skin produced by a lash, blow, or allergic stimulus. The skin is not broken and the mark is reversible. Factors to be Considered Not every cut, bruise, or welt constitutes an allegation of harm. The following factors should be considered when determining whether an injury which resulted in cuts, bruises or welts constitute an allegation of harm: - the child's age (children aged 6 and under are at a much greater risk of harm); - child's medical condition, behavioral, mental, or emotional problems, developmental disability, or physical handicap, particularly as they relate to the child's ability to protect himself or herself; - pattern or chronicity of similar incidents; - severity of the cuts, bruises, or welts (size, number, depth, extent of discoloration); - location of the cuts, bruises, or welts; - whether an instrument was used on the child; - previous history of indicated abuse or neglect.
12/62	Human Bites (Priority II) A bruise, cut or indentation in the skin caused by seizing, piercing, or cutting the skin with human teeth.
13/63	Sprains/Dislocations (Priority II) Sprain Trauma to a joint which causes pain and disability depending upon the degree of injury to ligaments. In a severe sprain, ligaments may be completely torn. The signs are rapid swelling, heat and disability, often discoloration and limitation of function. Dislocation The displacement of any part, especially the temporary displacement of a bone from its normal position in a joint. Types include: Complicated

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Allegation #	Definition
	A dislocation associated with other major injuries. Compound Dislocation in which the joint is exposed to the external air. Closed A simple dislocation. Complete A dislocation which completely separates the surfaces of a joint. Verification must come from a physician, registered nurse, licensed practical nurse or by a direct admission from the alleged perpetrator.
14	Tying/Close Confinement (Priority II) Unreasonable restriction of a child's mobility, actions or physical functioning by tying the child to a fixed (or heavy) object, tying limbs together or forcing the child to remain in a closely confined area which restricts physical movement. Examples include, but are not limited to: - locking a child in a closet. - tying one or more limbs to a bed, chair, or other object except as authorized by a licensed physician. - tying a child's hands behind his back.
15/65	Substance Misuse (Priority II) The consumption of a mood altering chemical capable of intoxication to the extent that it harmfully affects the child's health, behavior, motor coordination, judgment, or intellectual capability. Mood altering chemicals include cannabis (marijuana), hallucinogens, stimulants (including cocaine), sedatives (including alcohol and Valium), narcotics, or inhalants. Fetal alcohol syndrome or drug withdrawal at birth caused by the mother's addiction to drugs is included in this definition and is considered child neglect. Also included is any amount of a controlled substance or a metabolite thereof, found in the blood ~~or~~, urine or meconium (newborn's first stool) of a newborn infant. A controlled substance is defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act ~~(Ill.--Rev.--Stat. 1989,--ch.--56-1/2,--par.--1102)~~ [720 ILCS 570/102]. The

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Allegation #	Definition
	presence of such substances shall not be considered as child neglect if the presence is due to medical treatment of the mother or infant. NOTE: Methadone withdrawal or other withdrawal verified as under the auspices of a drug treatment program is not included under drug withdrawal at birth. Examples of substance misuse include, but are not limited to: - giving a minor (unless prescribed by a physician) any amount of heroin, giving a minor (unless prescribed by a physician) any amount of heroin, cocaine, morphine, peyote, LSD, PCP, pentazocine, or methaqualone or encouraging, insisting, or permitting a minor's consumption of the above substances~~,~~. - giving any mood altering substance, including alcohol or sedatives, unless prescribed by a physician, to an infant or toddler~~,~~. - encouraging, insisting or permitting a child who has not reached puberty to consume alcohol, drugs, or another mood altering substance on a regular or frequent basis~~,~~. - encouraging, insisting or permitting an adolescent to consume alcohol, drugs, or another mood altering substance on a daily basis~~,~~. - encouraging, insisting or permitting any minor to become intoxicated by alcohol, drugs, or another mood altering substance even if on an infrequent basis. Factors to be Considered The following factors should be considered when determining whether a child is involved in substance misuse. - age of the child. - frequency of substance misuse. - amount of substance consumption. - whether the substance is illegal. - degree of behavioral dysfunction, or physical impairment linked to substance misuse. - the child's culture, particularly as it relates to use of alcohol in religious ceremonies or on special occasions.

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Allegation #	Definition
	- whether the parent or caretaker's attempts to control an older child's substance misuse or to seek help for the child's substance misuse were reasonable under the circumstances. - whether the parent or caretaker knew or should have known of the child's substance misuse.
16	Torture (Priority I) Deliberately and/or systematically inflicting unusual or cruel treatment which results in physical or mental suffering.
17/67	Mental Injury (Priority II) Injury to the intellectual, emotional or psychological development of a child as evidenced by observable and substantial impairment in the child's ability to function within a normal range of performance and behavior, with due regard to his or her culture. Verification that a child has been mentally injured must come from a medical doctor, registered psychologist, certified social worker, registered nurse or professional employee of a community mental health agency.
18	Sexually Transmitted Diseases (Priority I) A disease which was acquired originally as a result of sexual penetration or sexual conduct with an individual who is afflicted. The diseases may include, but are not limited to: - Gonorrhea - Nonspecific Urethritis - Syphilis - Chancroid - Genital Candidiasis - Lymphogranuloma Venereum - Granuloma ~~Inguinale~~ Inguinale - Genital Herpes - Genital Warts - Balanoposthitis - Proctitis - Neisseria Gonorrhea - Chlamydia Trachomatis

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Allegation #	Definition
	- Treponema Pallidum - Haemophilus ~~Ducreyi~~ Ducreyi - Calymmatobacterium Granulomatis - Trichomonas Vaginalis (Symptomatic) - AIDS Sexual penetration is defined in the Illinois Criminal Sexual Assault Act as "any contact, however slight, between the sex organ or anus of one person by an object, ~~and~~ the sex organ, mouth or anus of another person, or any intrusion, however slight, of any part of the body of one person or any animal or object into the sex organ or anus of another person, including but not limited to cunnilingus, fellatio or anal penetration." Sexual conduct is defined in the Act as "any intentional or knowing touching or fondling of the victim or the perpetrator, either directly or through clothing of the sex organs, anus or breast of the victim or the accused, or any part of the body of a child . . . for the purpose of sexual gratification or arousal of the victim or the accused." Verification of sexually transmitted diseases must come from a medical source.
19	Sexual Penetration (Priority I) Any contact, however slight, between the sex organ or anus of one person by an object, ~~and~~ the sex organ, mouth or anus of another person, or any intrusion, however slight, of any part of the body of one person or any animal or object into the sex organ or anus of another person. This includes acts commonly known as oral sex (cunnilingus, fellatio), anal penetration, coition, coitus, and copulation.
20	Sexual Exploitation (Priority I) Sexual use of a child for sexual arousal, gratification, advantage, or profit. This includes but is not limited to: - indecent solicitation of a child/explicit verbal enticement~~;~~. - child pornography~~;~~. - exposing sexual organs to a child for the purpose of sexual arousal or gratification~~;~~.

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Allegation #	Definition
	- forcing the child to watch sexual acts~~,~~ ~~or~~. - self-masturbation in the child's presence. NOTE: Sexual penetration and molestation are excluded from this allegation. They are listed as separate allegations.
21	Sexual Molestation (Priority I) Sexual conduct with a child when such contact, touching or interaction is used for arousal or gratification of sexual needs or desires. Examples include, but are not limited to: - fondling. - the alleged perpetrator inappropriately touching or pinching parts of the child's body generally associated with sexual activity~~,~~ ~~or~~. - encouraging, forcing, or permitting the child to inappropriately touch parts of the alleged perpetrator's body generally associated with sexual activity.
22	Substantial Risk of Physical Injury (Priority II) Substantial risk of physical injury means that the parent, caretaker, immediate family member aged 16 or over, other person residing in the home aged 16 or over, or the parent's paramour has created a real and significant danger of physical injury or sexual abuse to the child. This allegation of harm is to be used when the type or extent of harm is undefined but the total circumstances lead a reasonable person to believe that the child is in substantial risk of physical injury or sexual abuse. This allegation of harm also includes incidents of violence or intimidation directed toward the child which have not yet resulted in injury or impairment but which clearly threaten such injury or impairment. Examples of incidents or circumstances which place the child in substantial risk of physical injury include, but are not limited to, the following: Incidents

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Allegation #	Definition
	- choking the child. - smothering the child. - pulling the child's hair out. - violently pushing or shoving the child into fixed or heavy objects. - throwing or shaking a smaller child. - other violent or intimidating acts directed toward the child which cause excessive pain or fear. Circumstances - domestic violence in the home when the child has been threatened and the threat is believable, as evidenced by a past history of violence, or uncontrolled behavior~~,~~. - a perpetrator of child abuse who has been ordered to remain out of the home returns home and has access to the abused child~~,~~. - the non-accidental death of one child provides reason to believe that another child is at risk~~,~~. - past sexual abuse, when confirmed by the victim, provides reason to believe that another child is at risk. Factors to be Considered Whether there is a real and significant danger is determined by the following factors: - the child's age (children aged 6 and under are at a much greater risk of harm)~~,~~. - the child's medical condition, behavioral, mental, or emotional problems, developmental disability, or physical handicap, particularly related to his or her ability to protect himself or herself~~,~~. - the severity of the occurrence~~,~~. - the frequency of the occurrence~~,~~. - the alleged perpetrator's physical, mental and/or emotional abilities, particularly related to his or her ability to control his or her actions~~,~~. - the dynamics of the relationship between the alleged perpetrator and the child~~,~~. - the alleged perpetrator's access to the child~~,~~. - the previous history of indicated abuse or neglect~~,~~. - the current stresses/crisis in the home~~,~~ ~~and~~. - the presence of other supporting persons in the home.

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Allegation #	Definition
74	Inadequate Supervision (Priority II) The child has been placed in a situation or circumstances which are likely to require judgment or actions greater than the child's level of maturity, physical condition, and/or mental abilities would reasonably dictate. Examples include, but are not limited to: - leaving children alone when they are too young to care for themselves. - leaving children alone who have a condition that requires close supervision. Such conditions may include medical conditions, behavioral, mental, or emotional problems, developmental disabilities or physical handicaps. - leaving children in the care of an inadequate or inappropriate caretaker. - being present but unable to supervise because of the caretaker's condition (This includes (1) the parent or caretaker who repeatedly uses drugs or alcohol to the extent that it has the effect of producing a substantial state of stupor, unconsciousness, intoxication or irrationality and (2) the parent or caretaker who cannot adequately supervise the child because of his or her medical condition, behavioral, mental, or emotional problems, developmental disability or physical handicap.). - leaving children unattended in a place which is unsafe for them when their maturity, physical condition, and mental abilities are considered. Factors to be Considered The following factors should be considered when determining whether a child is inadequately supervised. ~~1~~) Child Factors - child's age and developmental stage, particularly related to the ability to make sound judgments in the event of an emergency~~;~~ ~~and~~. - child's physical condition, particularly related to the child's ability to care for or protect himself or herself. Is the child physically or mentally handicapped, or otherwise in need of ongoing prescribed medical treatment such as periodic doses of insulin or

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Allegation #	Definition
	other medications? - child's mental abilities, particularly as related to the ability to comprehend the situation. - was the child's movement restricted or was the child otherwise locked within a room or other structure? ~~2~~) Caretaker Factors - presence or accessibility of caretaker. o How long does it take the caretaker to reach the child? o Can the caretaker see and hear the child? o Is the caretaker accessible by telephone? o Has the child been given phone numbers to call in the event of an emergency? - caretaker's age. o Is the caretaker mature enough to assume responsibility for the situation? - caretaker's physical and mental condition. o Is the caretaker able to make appropriate judgments on the child's behalf? ~~3~~) Incident Factors - frequency of occurrence. - duration of the occurrence (as related to the "child factors" above). - time of the day or night when the incident occurs. - child's location (the condition and location of the place where the minor was left without supervision). - the weather conditions, including whether the minor was left in a location with adequate protection from the natural elements such as adequate heat or light. - other supporting persons who are overseeing the child (Was the child given a phone number of a person or location to call in the event of an emergency and whether the child was capable of making an emergency call?). - whether food and other provisions were left for the child.

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Allegation # Definition

- other factors that may endanger the health and safety of the child.

75 Abandonment/Desertion (Priority II)

Abandonment

Abandonment is parental or caretaker conduct which demonstrates the purpose of relinquishing all parental rights and claims to the child. Abandonment is also defined as any parental or caretaker conduct which evinces a settled purpose to forego all parental duties and relinquish all parental claims to the child.

Desertion

Desertion is any conduct on the part of a parent or caretaker which indicates an intention to terminate custody of the child but not to relinquish all duties and claims on the child.

Examples of abandonment/desertion include, but are not limited to, parents or caretakers who:

- leave a baby on a doorstep.
- leave a baby in a garbage can.
- leave a child with no apparent intention to return.
- leave a child with an appropriate caretaker but fail to resume care of the child, as agreed, for a period of three months or more, and the caretaker cannot or will not continue to care for the child.

76 Inadequate Food (Priority III)

Lack of food adequate to sustain normal functioning. It is not as severe as Malnutrition or Failure to Thrive, both of which require a medical diagnosis.

Examples include:

- the child who frequently and repeatedly misses meals or who is frequently and repeatedly fed insufficient amounts of food.
- the child who frequently and repeatedly asks neighbors for food and other information substantiates that the child is not being fed.

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Allegation # Definition

- the child who is frequently and repeatedly fed unwholesome foods when his age, developmental stage, and physical condition are considered.

Factors to be Considered

~~1.~~ Child Factors

- child's age.
- child's developmental stage.
- child's physical condition, particularly related to the need for a special diet.
- child's mental abilities, particularly related to his ability to obtain and prepare his own food.

~~2.~~ Incident Factors

- frequency of the occurrence.
- duration of the occurrence.
- pattern or chronicity of occurrence.
- previous history of occurrences.
- availability of adequate food.

77 Inadequate Shelter (Priority III)

Lack of shelter which is safe and which protects the child(ren) from the elements.

Examples of inadequate shelter include, but are not limited to:

- no housing or shelter.
- condemned housing.
- exposed, frayed wiring.
- housing with structural defects which endanger the health or safety of a child.
- housing with indoor temperatures consistently below 50° F.
- housing with broken windows in sub-zero weather.
- housing which is a fire hazard obvious to the reasonable person.
- housing with an unsafe heat source which poses a fire hazard or threat of asphyxiation.

Factors to be Considered

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Allegation #	Definition
	~~1)~~ Child Factors - child's age. - child's developmental stage. - child's physical condition, particularly when it may be aggravated by the inadequate shelter. - child's mental abilities, particularly related to the child's ability to comprehend the dangers posed by the inadequate shelter. ~~2)~~ Shelter Factors - seriousness of the problem. - frequency of the problem. - duration of the problem. - pattern or chronicity of the problem. - previous history of shelter-related problems.
78	Inadequate Clothing (Priority III) Lack of appropriate clothing to protect the child from the elements. Factors to be Considered ~~1)~~ Child Factors - child's age. - child's developmental stage. - child's physical condition, particularly related to conditions which may be aggravated by exposure to the elements. - child's mental abilities, particularly related to his or her ability to obtain appropriate clothing. ~~2)~~ Incident Factors - frequency of the incident~~,~~. - duration of the incident~~,~~. - chronicity or pattern of similar incidents~~,~~. - weather conditions such as extreme heat or extreme cold.
79	Medical Neglect (Priority II) ~~A. MEDICAL OR DENTAL TREATMENT~~Medical or Dental Treatment

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Allegation #	Definition
	Lack of medical or dental treatment for a health problem or condition which, if untreated, could become severe enough to constitute a serious or long-term harm to the child; lack of follow-through on a prescribed treatment plan for a condition which could become serious enough to constitute serious or long-term harm to the child if the plan goes unimplemented. ~~B. IMMUNIZATIONS~~Immunizations Lack of immunizations required by ~~An Act in relation to the prevention of certain communicable diseases~~ Section 1 of the Communicable Disease Prevention Act ~~(Ill. Rev. Stat. 1985, ch. 111 1/2, pars. 22.11 and 22.12)~~ [410 ILCS 315] which states: *It is declared to be the public policy of this State that all children shall be protected, as soon after birth as medically indicated, by the appropriate vaccines and immunizing procedures to prevent communicable diseases which are or which may in the future become preventable by immunization.* The Department of Public Health has specified that the following immunizations are required unless there is a medical or religious reason why these immunizations should not be administered. The judgment of the family's physician with regard to whether there is a medical reason why immunization should not be administered shall be respected. - Diphtheria - Pertussis - Tetanus - Poliomyelitis - Measles - Rubella - Mumps The investigative worker shall give the parents 30 days to begin the required immunization series. Factors to be Considered - child's age, particularly as it relates to the ability to obtain treatment~~,~~.

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Allegation #	Definition
	- child's developmental stage~~,~~. - child's physical condition~~,~~. - seriousness of the current health problem~~,~~. - probable outcome if the current health problem is not treated and the seriousness of that outcome~~,~~. - generally accepted medical benefits of the prescribed treatment~~, and~~. - generally recognized side effects/harms associated with the prescribed treatment. It must be verified that the child has/had an untreated health problem, or that a prescribed treatment plan was implemented, or that the child has not started to receive immunizations required by State law within the 30-day period. Such verification must come from a physician, registered nurse, dentist, or by a direct admission from the alleged perpetrator. It must further be verified by a physician, registered nurse or dentist that the problem or condition, if untreated, could result in serious or long-term harm to the child.
80	No Allegation
81	Failure to Thrive (Priority I) (Non-Organic) A serious medical condition most often seen in children under one year of age. The child's weight, height and motor development fall significantly short of the average growth rates of normal children (i.e., below the fifth percentile). In about 10% of these cases, there is an organic cause such as a serious kidney, heart, or intestinal disease, a genetic error of metabolism or brain damage. All other cases are a result of a disturbed parent-child relationship manifested in severe physical and emotional neglect of the child. Non-organic failure to thrive requires a medical diagnosis before it may be indicated. Verification of failure to thrive must come from a physician.
82	Environmental Neglect (Priority III)

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Allegation #	Definition
	The child's person, clothing, or living conditions are unsanitary to the point that the child's health may be impaired. This may include infestations of rodents, spiders, insects, snakes, etc., human or animal feces, rotten or spoiled food or rotten or spoiled garbage which the child can reach. Factors to be Considered Special attention should be paid to the child's physical condition and the living conditions in the home in order to determine whether the report constitutes an allegation of harm. In addition, the following factors should be considered. ~~1)~~ Child Factors - child's age (children aged 6 and under are more likely to be harmed)~~,~~. - child's developmental stage~~,~~. - child's physical condition~~,~~. - child's mental abilities. ~~2)~~ Incident Factors - severity of the conditions~~,~~. - frequency of the conditions~~,~~. - duration of the conditions~~,~~. - chronicity or pattern of similar conditions.
83	Malnutrition (Priority I) (Non-Organic) Lack of necessary or proper food substances in the body caused by inadequate food, lack of food, or insufficient amounts of vitamin or minerals. (Also known as marasmus or kwashiorkor.) Non-organic malnutrition requires a medical diagnosis before it may be indicated. There are various physical signs of malnutrition: - A decrease in lean body mass or fat; very prominent ribs; the child may often be referred to as skin and bones. - The hair is often sparse, thin, dry, and is easily pulled out or falls out spontaneously. - The child is often pale and suffers from anemia.

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Allegation #	Definition
	- Excessive perspiration, especially about the head. - The face appear lined and aged, often with a pinched and sharp appearance. - The skin has an old, wrinkled look with poor turgor. (Classically, skin folds hang loose on the inner thigh and buttock.) - The abdomen is often protuberant. - There are abnormal pulses, blood pressure, stool patterns, intercurrent infections, abnormal sleep patterns and a decreased level of physical and mental activity. Verification of malnutrition must come from a physician.
84	Lock-Out (Priority II) The parent or caretaker has denied the child access to the home and has refused or failed to make provisions for another living arrangement for the child.
85	Medical Neglect of Disabled Infants (Priority I) The withholding of appropriate nutrition, hydration, medication or other medically indicated treatment from a disabled infant with a life-threatening condition. Medically indicated treatment includes medical care which is most likely to relieve or correct all life-threatening conditions and evaluations or consultations necessary to assure that sufficient information has been gathered to make informed medical decisions. Nutrition, hydration, and medication, as appropriate for the infant's needs, is medically indicated for all disabled infants. Other types of treatment are not medically indicated when: a. the infant is chronically and irreversibly comatose; b. the provision of the treatment would be futile and would merely prolong dying; or c. the provision of the treatment would be virtually futile and the treatment itself would be inhumane under the circumstances. In determining whether treatment will be medically indicated, reasonable medical judgments, such as those made by a prudent physician knowledgeable about the case and its treatment possibilities, will be respected. However, opinions about the infant's future "quality of life" are

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Allegation #	Definition
	not to bear on whether a treatment is judged to be medically indicated. Factors to be Considered - infant's physical condition; - seriousness of the current health problem; - probable medical outcome if the current health problem is not treated and the seriousness of that outcome; - generally accepted medical benefits of the prescribed treatment; - generally recognized side effects/harms associated with the prescribed treatment; - the opinions of the Infant Care Review Committee (ICRC), (if the hospital has an ICRC); - the judgment of the Perinatal Coordinator regarding whether treatment is medically indicated and whether there is credible evidence of medical neglect; and - the parent's knowledge and understanding of the treatment and the probable medical outcome. Verification that treatment was medically indicated must come from a physician and may come from experts in the field of neonatal pediatrics.

(Source: Amended at 19 Ill. Reg. 3469, effective MAR 15 1995)

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1) Heading of the Part: Illinois AmeriCorps Program

2) Code Citation: 47 Ill. Adm. Code 610

3) Section Numbers: Adopted Action:

610.10	New Section
610.20	New Section
610.30	New Section
610.40	New Section
610.50	New Section
610.60	New Section
610.70	New Section
610.80	New Section
610.90	New Section

4) Statutory Authority: Implementing the National and Community Service Trust Act of 1993 (42 U.S.C. 12501 et seq.) and the federal rules promulgated thereunder applicable to the AmeriCorps Program (45 CFR 2506, 2510, 2520, 2521, 2522, and 2540 (March 23, 1994))

5) Effective Date of Rules: March 6, 1995

6) Does this Rulemaking Contain an Automatic Repeal Date? No

7) Does this Rulemaking Contain Any Incorporation by Reference? Yes. See Section 610.30.

8) Date Filed in Agency's Principal Office: January 31, 1995

9) Date Notice of Proposal was Published in Illinois Register: October 28, 1994, 18 Ill. Reg. 15691

10) Has the Joint Committee Issued a Statement of Objection to these Rules? No

11) Difference Between Proposal and Final Version: A number of grammatical, punctuation, and non-substantive changes were made. No substantive changes were recommended or made.

12) Have all the changes agreed upon by the Agency and the Joint Committee been made as indicated in the agreement letter issued by the Joint Committee? Yes

13) Will the Rules Replace an Emergency Rule Currently in Effect? No

14) Are there any other Amendments Pending on this Part? No

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15) Summary and Purpose of Rules: In 1993 Congress passed the National and Community Service Trust Act of 1993 which, in addition to other programs, created a national service program entitled AmeriCorps. AmeriCorps is a federal program to be implemented by the states. In the State of Illinois, the program will be implemented and administered by the Office of the Lieutenant Governor. These proposed rules are designed to allow the Office of the Lieutenant Governor to carry out this responsibility.

16) State reason(s) for this rulemaking if it was not in either of the two (2) most recent regulatory agendas:

The full text of the Adopted Rules begins on the next page:

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TITLE 47: HOUSING AND COMMUNITY DEVELOPMENT
CHAPTER IV: OFFICE OF THE LIEUTENANT GOVERNOR

PART 610
ILLINOIS AMERICORPS PROGRAM

Section
610.10 Purpose and Summary
610.20 Definitions
610.30 Incorporation by Reference
610.40 State Implementation and Administration
610.50 Program Application Procedures
610.60 Applicant Selection Procedures
610.70 Member Recruitment and Selection
610.80 Monitoring of Programs
610.90 Invalidity

AUTHORITY: Implementing the National and Community Service Trust Act of 1993 (42 U.S.C. 12501 et seq.) and the federal rules promulgated thereunder applicable to the AmeriCorps program (45 CFR 2506, 2510, 2520, 2521, 2522, and 2540).

SOURCE: Adopted at 19 Ill. Reg. 3494, effective MAR 0 3 1995.

Section 610.10 Purpose and Summary

The purpose of these rules is to provide for the implementation and administration of AmeriCorps, a national service program created by the National and Community Service Trust Act of 1993, within the State of Illinois by the Lieutenant Governor and the Lieutenant Governor's Office of Voluntary Action. AmeriCorps is a federal program implemented by the states designed to address the nation's educational, public safety, human, and environmental needs by providing an opportunity for people to serve their communities in qualified programs and in return receive an educational award that can be used to repay student loans or for future education.

Section 610.20 Definitions

All words shall be defined according to definitions in the National and Community Service Trust Act of 1993 and the rules promulgated thereunder unless defined herein to the contrary.

"Act" means the National and Community Service Trust Act of 1993.

"Advisory Council" means the Lieutenant Governor's Advisory Council on Voluntary Action, and after January 9, 1995, the Lieutenant Governor's Commission on Community Service.

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"Applicant" means an organization or entity, public or private, that is eligible to apply for national service funds under the Act.

"Competitive category" means that category of educational award funds for which the State of Illinois is eligible to compete against other states for educational awards in addition to those allocated by the Corporation in the formula-funded category.

"Corporation" means the Corporation for National and Community Service, created by the Act.

"Formula-funded category" means that category of educational award funds allocated by the Corporation to the State of Illinois based on a population formula as provided by the Act.

"Member" means an individual who has been selected to serve in an approved AmeriCorps program.

"Partnership" means a joint arrangement among a group of organizations eligible to apply for national service funds under the Act.

"Program" means a planned and coordinated group of activities, procedures, etc. linked by common elements such as recruitment and selection of members, training for members and staff, regular group of activities, and assignment to projects, organized for the purpose of achieving the mission and goals of national service, and carried out with the assistance provided under the Act.

"Project" means an activity, carried out through a program that receives assistance under the Act, that results in a specific identifiable service or improvement that otherwise would not be done with existing funds, and that does not duplicate the routine services or functions of the employer to whom members are assigned.

Section 610.30 Incorporation by Reference

The following statutes and rules, not including any subsequent amendments or additions, shall be incorporated by reference herein and shall be available for inspection at or copies may be requested in writing from the Office of the Lieutenant Governor, James R. Thompson Center, Suite 15-200, Chicago, Illinois 60601:

a) The National and Community Service Trust Act of 1993 (42 U.S.C. 12501 et seq.).
b) The federal rules promulgated under the Act which apply to the AmeriCorps program found at 45 CFR 2506, 2510, 2520, 2521, 2522, and 2540 (March 23, 1994).

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Section 610.40 State Implementation and Administration

a) The Advisory Council shall serve as the state commission responsible for the implementation and administration of the program in the State of Illinois, pursuant to the requirements of the Act.

b) P.A. 88-597, effective January 9, 1995, renames the Lieutenant Governor's Office of Voluntary Action and the Lieutenant Governor's Advisory Council on Voluntary Action as the Lieutenant Governor's Commission on Community Service and makes certain changes in the structure of the Commission. All references in these rules to the "Lieutenant Governor's Office of Voluntary Action" and the "Lieutenant Governor's Advisory Council on Voluntary Action" shall be construed to reference the Lieutenant Governor's Commission on Community Service.

c) The Advisory Council's responsibility shall include the following:
   1) conduct a competitive process to select Illinois AmeriCorps programs to submit to the Corporation for approval;
   2) assist in the recruitment of qualified persons to serve in programs approved for funding by the Corporation; and
   3) monitor programs to insure quality.

Section 610.50 Program Application Procedures

a) Non-profit organizations, consortia of non-profit organizations, state agencies, higher education institutions, units of local government, and AmeriCorps programs are eligible to apply to the Advisory Council for national service funds under the Act.

b) Eligible applicants may apply for one or more of the following grants:
   1) Planning grant - The purpose of a planning grant is to bring a program to the verge of implementation so that it may compete successfully for operating assistance in the following grant cycle.
   2) Operating grant - The purpose of an operating grant is to support an organization that is ready to implement a fully developed plan for a new or expanded national service program.
   3) Educational award only - The purpose of this award is to provide national service educational awards to programs that do not apply for operating grants but meet the AmeriCorps program requirements and are judged to be high quality according to the criteria in this Part.

c) All applicants shall use application forms prepared and approved by the Advisory Council. The Lieutenant Governor's Office of Voluntary Action shall provide any interested parties upon request with application forms and descriptive information regarding the AmeriCorps program. Application requests shall be directed to the Office of the Lieutenant Governor, James R. Thompson Center, Suite 15-200, Chicago, Illinois 60601.

d) In addition to the use of approved forms, each application shall be submitted according to the following format. Applications shall be

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typed or printed in a font type not smaller than twelve (12) points. Except for the approved forms, all other documents included in the application shall be double-sided (each side counting as one page) and double-spaced. Applicants seeking support for an operating grant or an educational award only shall submit a single-program application package, and an applicant seeking support for a planning grant shall submit a planning grant application package. Each application package shall be organized and completed according to the applicable outline in either subsection (e) or (f) of this Section. Applicants seeking renewal of funding for an existing AmeriCorps program shall provide information in the application package that relates to the program's experience while receiving funding under the Act in addition to the information required of all applicants for the upcoming funding cycle.

e) A single-program application package shall consist of the following and shall be organized in the following order:
   1) Completed title page form.
   2) Table of contents page, not to exceed one (1) page in length, and providing the page numbers of each item requested in the application package.
   3) Application summary page, not to exceed one (1) page in length, and providing an overview of the following:
      A) Specific needs to be met, particularly as they relate to the national priorities of educational, public safety, human, and environmental needs as established by the Act.
      B) Key elements of the program design.
      C) Recruitment goals, including the percentage of members to be drawn from the national recruitment system, if any.
      D) A description of the administering organization and identification of the primary program partners, if any.
   4) Completed program mission and objectives form.
   5) Program narrative, not to exceed twenty (20) pages in length, and organized and labeled in the stipulated categories and providing the following information in a narrative form with as much specificity as possible:
      A) Need(s) To Be Met and Appropriateness For National Service.
         i) Needs. Identification of specific needs that the program will address and how these needs relate to the national priorities and how and why these needs are appropriately or uniquely addressed by a national service program. If the needs do not relate to a State or national priority area, an explanation why these needs were selected shall be provided.
         ii) Process. Description of the process by which the needs were identified, including specifying who was involved in identifying the needs and the extent of involvement of the residents of the community in which the service will be provided in the needs assessment activities.
      B) Program Design.

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i) Program Concept. Description of the basic concept for the design of the program, including the nature of the specific service activities to be performed by the members; the structure of the program; and its location. Description of any institutional or programmatic collaborations or partnerships that will be involved in operating the program, including the extent to which the program builds on existing infrastructure.

ii) Service Activities. Description of the activities in which members will engage and how these projects or activities will result in direct, measurable service that addresses the identified needs. Description of a typical week in the life of program members with concrete examples of the types of activities or duties members will perform.

iii) Relation To Need. Description of how the service activities respond to the identified needs and meet the program objectives.

iv) Member Training and Support. Description of how the members will be trained, supported, or otherwise prepared for their assignments or placements. Description of the key elements of the member training, in-service education, or service-learning curriculum employed to improve member's skills, prepare them for placement, and foster positive civic values.

v) Member Placement and Supervision. Description of how members will be placed (i.e., in teams or individually) and matched with an assignment. Description of how service sponsors or host-sites will be oriented and prepared for placement and how members will be supervised within the program.

C) Member Profile, Recruitment Strategy, and Benefits.

i) Number and Characteristics of Members. Identification of the expected number of members, including the total number and type (full-time or part-time), and characteristics, attributes or skills of members, including racial or ethnic background, socioeconomic status, gender, and educational attainment, to be recruited in the program. For programs recruiting fewer than twenty (20) members, an explanation why this smaller number is appropriate to the purpose and design of the program.

ii) Member Recruitment. Description of the methods that will be used or strategies undertaken to recruit members and the methods and strategies to achieve the program's recruitment goals.

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iii) Member Selection. Description of the strategies to be used to select members. Description of selection criteria, including minimum qualifications for members or requirements to possess any specialized skills to carry out service assignments. Determination as to whether any members will be drawn from the national recruitment system.

iv) Member Benefits. Description of the benefits members will receive, including the amount of the living allowance provided to each member. Explanation of how national service educational awards will be apportioned among program members, and if not provided to all members or to all members equally, an explanation of the program's rationale. Description of any alternative post-service benefits that might be used.

D) Internal Evaluation and Monitoring Activities.

i) Internal Evaluation and Monitoring. Explanation of how the program will monitor its progress toward the program objectives and how it will assess, on an ongoing basis, the quality of services and the satisfaction of both the members and the individuals or institutions served. Description of how the program will collect the required descriptive and demographic data.

ii) Previous Evaluation. If an applicant is proposing to replicate an existing program in other areas or is requesting a renewal for funding of an existing program, a statement as to whether the program proposed for replication, expansion, or renewal has been evaluated. If so, identification of who performed the evaluation and description of the results of the evaluation regarding community and participant impact. If the program has not been evaluated, a description of any evidence of successful performance or of a track record that will demonstrate its appropriateness for replication, expansion, or renewal.

E) Institutional and Personnel Information.

i) Principal Staff. Description of the background, experience, and major accomplishments of the program director and principal staff and how their qualifications relate to their duties and responsibilities for the proposed programs. If individuals have not yet been hired for these positions, a description of the qualifications candidates must fulfill.

ii) Training. Description of the kind of orientation and training, if any, the program will provide for staff.

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iii) Institutional Strengths. Description of the administering organization's past experience and institutional capacity to operate or coordinate a program comparable to the program(s) proposed, including a description of the institutional resources or expertise the administering organization(s) will provide that will contribute to the overall success of the program.

6) Completed budget form page and a budget narrative.

7) Completed assurances signature form.

8) Completed certification signature form.

f) A planning grant application package shall consist of the following and shall be organized in the following order:

1) Completed title page form.

2) Table of contents page, not to exceed one (1) page in length and providing the page numbers of each item requested in the application package.

3) Application summary page, not to exceed one (1) page in length, and providing an overview of the following:

A) Specific needs to be met, particularly as they relate to the national priorities of educational, public safety, human, and environmental needs as established by the Act.

B) The mission and objectives for the planning process.

C) An overview of how the program will address the identified needs.

D) A description of the administering organization and identification of its leadership and primary program partners, if any.

4) Program narrative, not to exceed twenty (20) pages in length, and organized and labeled in the stipulated categories and providing the following information in a narrative form with as much specificity as possible:

A) Needs To Be Targeted.

i) Need(s). Identification and specific description of the need(s) from the national priorities which the program seeks to address.

ii) Process. Description of the process by which the needs were identified, including specifying who was involved in identifying the needs.

iii) Community Resources. Description of how the proposed program will build on or collaborate with other programs in the community, including federal programs that address these needs.

B) Planning Activities.

i) Program Concept. Description of the basic concept that has been developed for meeting the identified need(s), and identification of the specific objectives for the planning phase.

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ii) Planning Process. Description of the anticipated planning process, the tasks to be carried out, and the timeline of the process.

iii) Community Involvement. Description of persons or entities, such as prospective members, representatives of the community served, community-based agencies with a demonstrated record of experience in providing services, businesses, and labor organizations, to be involved in the planning process and how they as a group reflect the community to be served. Identification of the individuals or organizations, if any, responsible for particular tasks.

C) Institutional and Personnel Information.

i) Institutional Strengths. Description of the qualifications of the administering organization and its past experience and track record in designing new programs.

ii) Principal Staff. Description of the background, experience, and major accomplishments of the program director in designing new programs. If a program director has not yet been hired, a description of the qualifications a candidate must fulfill.

5) Completed budget form page and a budget narrative.

6) Completed assurances signature form.

7) Completed certification signature form.

Section 610.60 Applicant Selection Procedures

a) The Advisory Council shall have the responsibility of reviewing the Illinois AmeriCorps program proposals in both the formula-funded and competitive categories and selecting the proposals for submission for federal funding to the Corporation. As part of this review process, the Advisory Council shall have the authority to consult with persons with specialized knowledge in the subject matter of any of the priorities established by the Act for national service. The decisions of the Advisory Council shall be final and binding. Applicants shall be notified by mail of the decision of the Advisory Council. Programs whose proposals have been selected for submission for federal funding to the Corporation shall be notified by the Lieutenant Governor of the decision of the Corporation relating to their proposals.

b) The Advisory Council shall first determine whether the applicant's proposal meets the following three (3) program requirements of community impact, strengthening communities, and improving citizenship and skills of members:

1) The proposal shall meet educational, public safety, human, or environmental needs in the community served and provide a direct and demonstrable benefit that is valued by the community.

A) Service that provides a direct benefit includes physical

projects such as renovating low-income housing or creating a playground in a vacant lot, and human service projects such as tutoring, mentoring, or conflict resolution. Eligible activities also include supervising participants or volunteers whose service provides a direct benefit to the community. In all cases, service activities shall result in a specific identifiable service or improvement that otherwise would not be provided with existing funds or volunteers and that does not duplicate the routine functions of workers or displace paid employees. Activities that do not provide a direct benefit to the community, such as clerical work or research, may be performed if they are in support of a direct service. However, such activities may not be the primary activity of a service program. For example, a team whose project involves providing meals, transportation, and health services to the homebound may need to conduct a door-to-door survey of community residents to help locate those in need of services. If they then go on to provide those services, this kind of research would be an appropriate activity for the team.

B) To determine whether the community values or will value the service proposed, the Advisory Council shall consider the nature, sustainability, and quality of the proposed service and how it meets community needs as identified by needs assessment activities.

2) The program shall strengthen communities, bring together both institutions and individuals to cooperate in bringing about lasting and constructive change.

A) Programs must perform projects that are designed, implemented, and evaluated with extensive and broad-based local input, including consultation with representatives from the community served, members (or potential members) in the program, community-based agencies with a demonstrated record of experience in providing services, foundations, businesses, and local labor organizations representing employees of service sponsors if these entities exist in the area observed by the program.

B) Applicants shall agree to seek actively to include members from the communities in which projects are conducted, as well as individuals of different races and ethnicities, socioeconomic backgrounds, both men and women, and individuals with disabilities. Programs that lack diversity in some manner must strive for diversity in other ways. For example, programs that do not achieve diversity among members in all areas may seek it by involving a diverse group of additional volunteers in other service alongside members. The Council recognizes that certain programs require the recruitment of members who share a specific

characteristic or background, such as a professional corps that requires members to possess specific post-secondary training which might inadvertently cause a lack of diversity. Such programs must still not violate non-discrimination provisions of the Act and the rules promulgated thereunder or this Part relating to member selection.

3) Programs shall improve the citizenship and the skills of members.

A) Programs shall help members develop, through their service experiences, the ethic and skills needed for productive, active citizenship which includes developing their skills in solving community problems and cultivating a lifelong ethic of productive, active citizenship. Programs shall ensure, in a non-partisan manner, that each member who is eligible to vote registers to vote.

B) Programs shall be designed to have particular impacts on members related to the mission of the program. For example, members may improve particular skills, learn the importance of using specialized skills to address pressing needs, or develop leadership and managerial skills.

C) Programs shall provide members with the training, skills, and knowledge necessary to perform the tasks required in their respective projects. Programs shall provide members with background information on the community to help them understand why the service project is needed. Programs may also provide, if appropriate, specific training and education designed to help members explore career possibilities in areas such as child development, teaching, public health, or public safety.

D) Programs shall provide support services to members at the end of their term of service to make the transition to other educational or career opportunities and to assist members who are school dropouts to earn the equivalent of a high school diploma.

c) Programs applying for operating grants including educational awards or for educational awards only, which have been found by the Advisory Council to meet the three (3) program requirements as provided above, will be competitively evaluated by the Advisory Council based on the following criteria.

1) The Advisory Council shall take into consideration the extent to which both the program overall and its particular projects will address needs important to the community and be conducted in areas of need as defined in the Act. This portion of the evaluation shall compose ten (10) percent of the total.

2) The Advisory Council shall consider the quality of the program based on the program design and organizational capacity.

A) Consideration of the program design shall comprise forty (40) percent of the evaluation and is based upon the

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following criteria:

i) The potential impact of using proposed national service members to meet the community needs being addressed.

ii) Inclusion of a clear and compelling mission statement.

iii) Identification of specific objectives and indicators of success.

iv) Development of an effective recruitment, selection, and training plan for staff and members, including recruitment of members and staff from the community to be served.

v) Ability to provide appropriate supervision, counseling, service-learning and other education opportunities, and outplacement to members.

vi) The involvement of members and community residents in the design, operation, and leadership of the program.

vii) Development of a sound plan for continually improving the program based on self-assessment and monitoring of community and member satisfaction with work performed.

viii) Inclusion of an appropriate organization and staffing plan.

ix) The program's cost-effectiveness in achieving identified outcomes, including per member cost.

B) Consideration of organizational capacity shall comprise thirty (30) percent of the evaluation and is based upon the following criteria.

i) The quality of the leadership of the program.

ii) The past performance of the organization or program.

iii) The organization's connection to the community.

iv) The extent to which the program builds on existing programs.

v) Evidence of strong and broad-based community support for the program.

vi) Availability of additional funding sources for the program.

C) In addition to the above, an application proposing the replication of an existing program shall be evaluated on the following criteria.

i) The success of the program in its original site, including the results of any evaluation undertaken.

ii) The program's analysis of the strengths and weaknesses of the original program.

iii) Reasons for selecting the replication site and discussion of the adjustments needed for adaption to a new site.

iv) The qualification of the leaders of the program at the new site.

3) The Advisory Council shall consider the ability of the program to

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sustain itself beyond the period of Corporation support. This portion shall comprise ten (10) percent of the evaluation and is based upon the following criteria.

A) Evidence of strong and broad-based community support.

B) Presence of multiple or private funding sources.

C) Cost-effectiveness.

D) Additional consideration will be given to programs that significantly exceed the local match with non-federal funds and to federal agencies that are providing a substantial match to Corporation funds.

4) The Advisory Council shall consider the degree to which needs coincide to program design, the innovative aspects of the program, and the appropriateness of replicating the program in the future. This portion shall comprise ten (10) percent of the evaluation.

5) In addition to the criteria on which individual applications will be rated, the Advisory Council shall give priority consideration to the following issues.

A) The Advisory Council seeks a broadly diverse member pool that includes the following:

i) A large representation of young adults.

ii) A proportionate ratio of individuals who have not attended college and those with college-education experience.

iii) Approximately equal numbers of men and women.

iv) Individuals of all races and ethnicities.

v) Individuals with physical and cognitive disabilities.

B) The Advisory Council anticipates funding a range of program types that will yield the desired member pool.

C) The Advisory Council shall ensure that the programs funded are geographically diverse and include projects in both urban and rural areas.

D) The Advisory Council may fund programs that will enable it to test the effect of concentrating a critical mass of members in a small geographic area such as a rural community, small city, or part of a larger city.

E) The Advisory Council shall give special consideration to programs able to start-up quickly as a result of having completed a planning phase, programs having start dates in late August or September or January, and programs able to leverage funds at a level beyond that required by the Act.

6) The program shall be in conformance with all requirements of the Act and the rules promulgated thereunder.

d) Programs applying for planning grants that have been found by the Advisory Council to meet the three (3) program requirements as provided in subsection (a) of this Section shall be competitively evaluated by the Advisory Council based on the following criteria.

1) The criteria enumerated in subsections (c)(1), (c)(2)(A), and

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(c)(6) of this Section shall apply to the Advisory Council's consideration of applications for planning grants. For the purposes of this subsection, such criteria shall be construed to apply to potential or proposed programs.

2) The quality of the plan for developing the program.
3) The track record of the organization in launching new initiatives.
4) The appropriateness of the planning budget.
5) The ability of the proposed program to become operational.
6) The degree to which planning objectives coincide with the design of the proposed program.
7) Consideration of the criteria enumerated in subsections (c)(2) through (c)(6) of this Section shall each comprise ten (10) percent of the evaluation.

Section 610.70 Member Recruitment and Selection

a) Each approved AmeriCorp program shall be responsible for the recruitment, interview, and selection of qualified members who possess leadership potential and a commitment to the goals of the AmeriCorps program, regardless of educational level, work experience, or economic background. Programs shall select members in a non-partisan, non-political, and non-discriminatory manner.

b) A program may undertake its own recruitment efforts for prospective members and/or it may seek prospective members from the Corporation's national recruitment system and/or the Illinois referral list which shall be maintained by the Advisory Council. The Advisory Council shall work with approved programs at their request to select some members from the Illinois and national recruitment systems in order to supplement local recruitment with people who are from different backgrounds and regions of the nation, have special skills or training, and desire to serve but live in areas where there are few or no national service programs.

c) The Advisory Council shall prepare and approve an application form which shall be used by all prospective Illinois AmeriCorps members when making application to an approved program or when submitting their application to the Advisory Council for inclusion in the Illinois referral list. Nothing herein shall preclude an approved program from requesting or requiring further information from prospective members provided that any such requests or requirements for further information are not inconsistent with the Act and the rules promulgated thereunder or with this Part.

d) To ensure that members understand what will be expected from them, programs shall use member contracts that stipulate terms of service, acceptable conduct, duties and responsibilities, grievance procedures, termination rules, and other conditions and terms not inconsistent with the Act and the rules promulgated thereunder or with this Part.

OFFICE OF THE LIEUTENANT GOVERNOR

NOTICE OF ADOPTED RULES

Section 610.80 Monitoring of Programs

a) The Advisory Council shall be responsible for ongoing efforts to monitor the quality and finances of approved Illinois AmeriCorps programs and their conformance with all requirements of the Act and the rules promulgated thereunder and with this Part. Nothing contained herein shall affect or limit in any manner the authority of the Corporation to also monitor approved Illinois AmeriCorps programs. All approved Illinois AmeriCorps programs shall cooperate with the monitoring activities of both the Corporation and the Advisory Council.

b) The Advisory Council shall have the responsibility of preparing the state report required by 45 CFR 2522 and shall collect from the approved Illinois AmeriCorps programs such information as is necessary to complete this report.

c) The Advisory Council shall follow and use the same criteria as used by the Corporation to monitor programs as are provided in the rules promulgated under the Act.

d) Each approved Illinois AmeriCorps program shall be responsible for submitting to the Advisory Council quarterly reports and a final report for the funding cycle. These reports shall provide information on the program's progress in meeting its objectives, such other information as is specified in the rules promulgated under the Act, and the program's finances. Each year, at the beginning of the funding cycle, the Advisory Council shall set a schedule for submission of reports to itself.

e) The Advisory Council shall have the authority to make site visits to each approved Illinois AmeriCorps program, provided that 24 hour written advance notice is given to the program.

f) The Advisory Council shall also make a close-out site visit to each approved Illinois AmeriCorps program near or at the end of the funding cycle to review each program programmatically and financially.

Section 610.90 Invalidity

If any portion of this Part shall be held by a court of competent jurisdiction to be invalid, such holding shall not affect the remaining portions thereof.

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NOTICE OF EMERGENCY AMENDMENTS

1) Heading of the Part: Hospital Services

2) Code Citation: 89 Ill. Adm. Code 148

3) Section Numbers: Emergency Action:

148.25	Amendment
148.120	Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, par. 12-13) [305 ILCS 5/12-13]

5) Effective Date of Amendments: March 1, 1995

6) If these Emergency Amendments are to expire before the end of the 150-day period, please specify the date on which it is to expire: Not Applicable

7) Date Filed in Agency's Principal Office: March 1, 1995

8) Reason for Emergency: These emergency amendments pertaining to hospital services are being filed pursuant to a Department initiative to make facilities operated by the Department of Mental Health and Developmental Disabilities (DMHDD) eligible for disproportionate share payments (DSH). These amendments will maximize federal financing benefits to hospitals as permitted by Illinois' federal DSH spending limitations. The DSH payment amount made to each facility will be determined according to a methodology consistent with current DSH formulas and include mechanisms to ensure compliance with OBRA '93 guidelines and federal DSH spending limitations. Immediate implementation of these amendments is necessary to capture the greatest possible economic benefit for State owned hospitals and thereby ensure that access to necessary health care is maintained and enhanced.

9) Complete Description of the Subjects and Issues Involved: These emergency amendments to the Department's rules pertaining to hospital services provide that State owned facilities operated by the Department of Mental Health and Developmental Disabilities (DMHDD) shall be eligible for disproportionate share (DSH) hospital adjustments for services delivered on or after March 1, 1995. The Department is initiating this action to maximize federal financing benefits to hospitals as permitted by Illinois' federal DSH spending limitations. The DSH payments for DMHDD operated facilities shall be in addition to the reimbursements currently paid for services provided by these facilities. The DSH payment amount made to each facility will be determined according to a methodology consistent with current DSH formulas and include mechanisms to ensure compliance with OBRA '93 guidelines and federal DSH spending limitations.

These amendments are expected to result in an enhancement of federal financial participation by approximately $8.5 million in fiscal year 1995.

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10) Are there any Proposed Amendments pending to this Part? No

11) Statement of Statewide Policy Objectives: These emergency amendments do not affect units of local government.

12) Information and questions regarding these Emergency Amendments shall be directed to:

Name: Joanne Jones
Address: Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, Illinois 62762
Telephone: (217) 524-3215

The full text of the Emergency Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

Section
148.10 Hospital Services
148.20 Participation
148.25 Definitions and Applicability
EMERGENCY
148.30 General Requirements
148.40 Special Requirements
148.50 Covered Hospital Services
148.60 Services Not Covered as Hospital Services
148.70 Limitation On Hospital Services
148.80 Organ Transplants Services Covered Under Medicaid (Repealed)
148.82 Organ Transplant Services
148.90 Heart Transplants (Repealed)
148.100 Liver Transplants (Repealed)
148.110 Bone Marrow Transplants (Repealed)
148.120 Disproportionate Share Hospital (DSH) Adjustments
EMERGENCY
148.130 Outlier Adjustments for Exceptionally Costly Stays
148.140 Hospital Outpatient and Clinic Services
148.150 Uncompensated Care Payment Adjustments
148.160 Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million
148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act
148.180 Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting
148.190 Copayments
148.200 Alternate Reimbursement Systems
148.210 Filing Cost Reports
148.220 Pre September 1, 1991 Admissions
148.230 Admissions Occurring on or after September 1, 1991
148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals
148.260 Calculation and Definitions of Inpatient Per Diem Rates
148.270 Determination of Alternate Cost Per Diem Rates for All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals
148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements
148.290 Adjustments and Reductions to Total Payments

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148.300 Payment
148.310 Review Procedure
148.320 Alternatives
148.330 Exemptions
148.340 Subacute Alcoholism and Substance Abuse Treatment Services
148.350 Definitions
148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services
148.368 Volume Adjustment (Repealed)
148.370 Payment for Subacute Alcoholism and Substance Abuse Treatment Services
148.373 Utilization (Repealed)
148.376 Utilization, Case-Mix and Discretionary Funds
148.380 Rate Appeals for Subacute Alcoholism and Substance Abuse Treatment Services
148.390 Hearings
148.400 Special Hospital Reporting Requirements

AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 6503-1 et seq.) [20 ILCS 2215/Art. III] and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13) [305 ILCS 5/Arts. III, IV, V, VI and VII and 12-13].

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18

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Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. ~~3510~~, effective March 1, 1995, for a maximum of 150 days.

Section 148.25 Definitions and Applicability
EMERGENCY

a) Payment for hospital inpatient, hospital outpatient and hospital clinic services shall be made only to a hospital or a distinct part hospital unit as defined in this Section.

b) The term "hospital" means:

1) For the purpose of hospital inpatient reimbursement, any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which is located in the State and is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act or any institution, place, building or agency, public or private, whether organized for profit or not-for-profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located. In addition, unless specifically indicated otherwise, for the purpose of inpatient reimbursement, the term "hospital" shall also include:

A) County-owned hospitals, shall mean all county-owned hospitals~~,~~ that are located in an Illinois county with a population of over 3 million.

B) A hospital ~~and/or hospitals~~ organized under the University of Illinois Hospital Act.

C) A hospital unit that is adjacent to or on the premises of the hospital and licensed under the Hospital Licensing Act or the University of Illinois Hospital Act.

2) For the purpose of hospital outpatient reimbursement, the term "hospital" shall, in addition to the definition described in subsection (b)(1) above, include an encounter rate hospital. An encounter rate hospital is defined as:

A) An Illinois county-owned hospital located in a county with a population exceeding 3 million; or

B) A hospital and/or hospitals organized under the University of Illinois Hospital Act.

C) A county-operated outpatient facility located in a county with a population exceeding 3 million that is also located in the State of Illinois.

3) For the purpose of non hospital-based clinic reimbursement, the term "hospital" shall mean:

A) A county-operated outpatient facility, as described in subsection (b)(2)(D) above; or

B) A Certified Hospital Organized Satellite Clinic, as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and subsection (b)(5)(B) below.

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4) For the purpose of hospital-based clinic reimbursement, the term "hospital" shall mean a hospital-based clinic meeting the provisions of 89 Ill. Adm. Code 140.461(a) and Section 148.40(d).

5) For the purpose of Healthy Moms/Healthy Kids reimbursement, as described in 89 Ill. Adm. Code 140.464 and Section 148.140(d)(6), the term "Healthy Moms/Healthy Kids managed care clinic" shall mean a clinic meeting the requirements of 89 Ill. Adm. Code 140.461(f). The following four categories of Healthy Moms/Healthy Kids managed care clinics are recognized under the Healthy Moms/Healthy Kids Program, as described in 89 Ill. Adm. Code 140, Subpart G:

A) Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A);

B) Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B);

C) Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C); and

D) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D).

6) For the purpose of disproportionate share hospital adjustments, the term "hospital" shall, in addition to the definition described in subsection (b)(1) above, include the facilities operated by the Department of Mental Health and Developmental Disabilities which are accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO).

c) For the purpose of hospital inpatient reimbursement, the term "distinct part hospital unit" means a hospital, as defined in subsection (b)(1) above, that meets the following qualification(s):

1) Distinct Part Psychiatric Units. A distinct part psychiatric unit is a hospital, with a functional psychiatric unit, that is enrolled with the Department to provide inpatient psychiatric services (category of service 21).

2) Distinct Part Rehabilitation Units. A distinct part rehabilitation unit is a hospital, with a functional rehabilitation unit, that is enrolled with the Department to provide inpatient rehabilitation services (category of service 22).

d) A major teaching hospital is defined as a hospital having four or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post - doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation. Except, in the case of a hospital devoted exclusively to physical rehabilitation, as defined in 89 Ill. Adm. Code 149.50(c)(2), or in the case of a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3), only one certified program is required to be so

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classified.

e) Except as provided in subsection (d) above, a teaching hospital is defined as a hospital having at least one, but no more than three, graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.

f) A non-teaching hospital is defined as:
   1) A hospital that reports teaching costs on the Medicare or Medicaid cost reports but has no graduate medical education programs; or
   2) A hospital that reports no teaching costs on the Medicare or Medicaid cost reports and that has no graduate medical education programs.

g) Definitions. Unless specifically stated otherwise, the definitions of terms used in Sections 148.130, 148.260, 148.270, and 148.280, and in 89 Ill. Adm. Code 149 are as follows:
   1) "Base period" means the two most recent cost report years for which audited cost reports are available for at least 90 percent of cost reporting hospitals.
   2) "Rate period" means:
      A) For admissions, or if applicable, dates of service, on or after October 1, 1992, and on or before March 31, 1994, the eighteen month period beginning on October 1, 1992, and ending on March 31, 1994.
      B) Beginning with admissions, or if applicable, dates of service, on or after April 1, 1994, the period beginning 90 days after the effective date of DRG PPS rates under the federal Medicare Program and ending 90 days after any subsequent DRG PPS rate change under the federal Medicare Program.
   3) "Rural hospital" means a hospital that is:
      A) Located:
         i) Outside a metropolitan statistical area; or
         ii) Located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health.
      B) The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993).
   4) "Urban hospital" means a hospital that is located in a metropolitan statistical area that does not meet the criteria

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described in subsection (g)(3) above.

(Source: Emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days)

Section 148.120 Disproportionate Share Hospital (DSH) Adjustments
EMERGENCY

Disproportionate Share Hospital (DSH) adjustments for inpatient services provided prior to October 1, 1993, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 1993, and each October 1, thereafter unless otherwise noted.

a) Qualified Disproportionate Share Hospitals (DSH). For inpatient services provided on or after October 1, 1993, the Department shall make adjustment payments to hospitals which are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:
   1) The hospital's Medicaid inpatient utilization rate, as defined in subsection (1)(5) of this Section, is at least one half standard deviation above the mean Medicaid utilization rate, as defined in subsection (1)(3) of this Section.
   2) The hospital's low income utilization rate exceeds 25 per centum. For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance), Aid to the Medically Indigent (AMI) and/or any local or state government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for GA and AMI inpatient hospital services, and/or any local or state government-funded care) must be added.
   3) Illinois hospitals that, on July 1, 1991, had a Medicaid inpatient utilization rate, as defined in subsection (1)(5) of this Section, that was at least the mean Medicaid inpatient utilization rate, as defined in subsection (1)(3) of this Section, and which were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (42 CFR 5, 1989).
   4) Illinois hospitals that:
      A) Have a Medicaid inpatient utilization rate, as defined in subsection (1)(5) of this Section, which is at least the mean Medicaid inpatient utilization rate, as defined in subsection (1)(3) of this Section, and
      B) Have a Medicaid obstetrical inpatient utilization rate, as

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defined in subsection (1)(6) of this Section, that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (1)(4) of this Section.

5) Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality shall be considered a children's hospital to the degree that the hospital's medical assistance care is provided to children.

b) In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least 2 obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4), must submit a statement to that effect.

c) In making the determination described in subsections (a)(1) and (a)(4)(A) above, the Department shall utilize:

1) The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in subsection (1)(5) of this Section, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.

2) In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsections (a)(1) and (a)(4)(A) above. Submittal of a corrected cost report in support of subsections (a)(1) and (a)(4)(A) above must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's Medicaid inpatient utilization rate as described in subsection (1)(5) of this Section.

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A) Hospital's Medicaid inpatient utilization rates, as defined in subsection (1)(5) of this Section, which have been derived from unaudited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsection (c)(2) above, hospitals shall have the opportunity to submit corrected cost report information prior to the Department's final DSH determination.

B) In the event a subsequent final audited cost report reflects a Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section, which is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report utilized for the DSH determination, the Department shall recalculate the Medicaid inpatient utilization rate based upon the final audited cost report, and recoup any overpayments made.

3) Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, HMO days, and inappropriate level of care days. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

A) Medicare/Medicaid Crossover Claims. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Hospitals may submit additional information to document Medicare/Medicaid crossover days which were not billed to the Department due to a determination that the Department had no liability for deductive and/or coinsurance amounts. This information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total number of Medicare/Medicaid crossover days. This log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days which were not billed to the Department for services provided during the hospital's base fiscal year. If a hospital does not submit a log of Medicare/Medicaid crossover days that meets the above requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.

B) Out-of-state Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient

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utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.

C) HMO days. The Department will utilize the Department's HMO claims data available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an HMO.

D) Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care inappropriate level of care days provided to recipients.

d) Hospitals may apply for DSH status under subsection (a)(2) by submitting an audited certified financial statement for the hospital's base fiscal year. The Department of Mental Health and Developmental Disabilities must submit a statement, signed by the Director of that agency, certifying the accuracy of the data submitted for facilities operated by that agency. The ~~audited certified financial statement~~ statements must contain the following breakdown of information prior to submittal to the Department for consideration:

1) Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

2) Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

3) Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts, except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance, and AMI patients), for the hospital's base fiscal year.

4) Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.

e) With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals that qualify for DSH in the state in which they are located based upon the Federal definition of a DSH hospital, as defined in Section 1923(b)(1) of the Social Security Act, may qualify for DSH hospital adjustments under this Section. For purposes of determining the Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section and as required in Section 1923(b)(1) of the Social Security Act, out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not qualify by the Medicaid inpatient utilization rate from their state may submit an audited certified financial statement as describe in

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subsection (d) above. Payments to out-of-state hospitals will be allocated using the same methods as described in subsection (g).

f) Time Limitation Requirements for Additional Information.

1) The information required in subsections (a)(2), (c), (d) and (e) must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such information for the determination of DSH qualification. Information required in this Section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

2) The information required in subsection (b) must be received within 30 calendar days after receipt of notification from the Department that the information must be submitted. Information required in this Section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

g) Inpatient Payment Adjustments to DSH. The adjustment payments required by subsection (a) above shall be calculated annually as follows:

1) Five Million Dollar Fund Adjustment for hospitals defined in Section 148.25(b)(1).

A) Hospitals qualifying as DSH hospitals under subsection (a)(1) that have a Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, as described in subsection (1)(3) of this Section, and hospitals qualifying as DSH hospitals under subsection (a)(2) of this Section will receive an add-on payment to their inpatient rate.

B) The distribution method for the add-on payment described in subsection (g)(1)(A) above is based upon a fund of $5 million. All hospitals qualifying under subsection (g)(1)(A) above will receive a $5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by $5. The total dollar amount of this calculation is then subtracted from the $5 million fund.

C) The remaining fund balance is then distributed to the hospitals that qualify under subsection (a)(1) that have a Medicaid inpatient utilization rate, as described in subsection (1)(5) of this Section, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, above in proportion to the percentage by which the hospital's Medicaid inpatient utilization rate

exceeds one standard deviation above the State's Medicaid inpatient utilization rate, as described in subsection (l)(3) of this Section. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the $5 million pool of money available after the$5 per day base add-on has been subtracted.

D) The total dollar amount calculated for each qualifying hospital under subsection (g)(l)(C) above, plus the initial$5 per day add-on amount calculated for each qualifying hospital under subsection (g)(l)(B) above, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at per day add-on value. Hospitals qualifying under subsection (a)(2), will receive the minimum adjustment of$5 per inpatient day. The adjustments calculated under this subsection are subject to the limitations described in subsection (k) of this Section.

2) Medicaid Percentage Adjustment for hospitals defined in Section 148.25(b)(1).

A) In addition to the adjustment methodology described in subsection (g)(l) above, all DSH hospitals described in subsection (a)(1), (2), (3) (4), and (5) shall receive a payment adjustment which shall be calculated annually as follows:

B)~~A)~~ The payment adjustment shall be calculated based upon the hospital's Medicaid inpatient utilization rate, as defined in subsection (l)(5) of this Section, and subject to subsections (h), (i), and (j) below, as follows:

i) Hospitals with a Medicaid inpatient utilization rate below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25;

ii) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean

Medicaid inpatient utilization rate;

iii) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $40 plus $7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate and;

iv) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $90 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate.

C)~~B)~~ For county-owned hospitals, as described in Section 148.25(b)(1)(A), or a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), the amount calculated pursuant to subsection (g)(2)(B) ~~(g)(2)(A)~~ above shall be increased by $60 per day.

D)~~C)~~ The Medicaid percentage adjustment payment, calculated in accordance with this subsection (g)(2), to a hospital, other than county-owned hospitals, as described in Section 148.25(b)(1)(A), or hospital and/or hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), shall not exceed $155 per day for a children's hospital, as described in subsection (a)(5) of this Section, and shall not exceed $215 per day for all other hospitals.

E)~~D)~~ The amount calculated pursuant to subsections (g)(2)(B) ~~(g)(2)(A)~~ through (g)(2)(D) ~~(g)(2)(C)~~ above shall be adjusted on October 1, 1993, and annually thereafter by a percentage equal to the lesser of:

i) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

ii) The percentage increase in the statewide average hospital payment rate, as described in subsection (l)(8) of this Section, over the previous year's statewide average hospital payment rate

F)~~E)~~ The amount calculated pursuant to subsections (g)(l) and (g)(2)(B) ~~(g)(2)(A)~~ through (g)(2)(E) ~~(g)(2)(D)~~ above for

hospitals described in Section 148.25(b)(1)(A) shall be no less than the DSH rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

G)~~F)~~ The amount calculated pursuant to subsections (g)(1) and (g)(2)(B) ~~(g)(2)(A)~~ through (g)(2)(E) ~~(g)(2)(D)~~ above, as adjusted pursuant to subsections (h), (i), and (j) below, shall be the inpatient payment adjustment in dollars for the applicable DSH determination year, subject to the limitations described in subsections (g)(2)(D) ~~(g)(2)(C)~~ and (k) of this Section, and the adjustment described in subsection (g)(2)(F) ~~(g)(2)(E)~~ above. The adjustments calculated under subsections (g)(1) and (g)(2)(B) ~~(g)(2)(A)~~ through (g)(2)(F) ~~(g)(2)(E)~~ of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.

3) DMHDD State-Operated Facility Adjustment for hospitals defined in Section 148.25(b)(6). Department of Mental Health and Developmental Disabilities (DMHDD) state-operated facilities qualifying under subsection (a)(2) shall receive an adjustment effective for inpatient services on or after March 1, 1995. The amount of that payment shall be calculated as follows.

A) The amount of the adjustment is based on a State DSH Pool. The State DSH pool amount shall be calculated by subtracting the estimated DSH payment adjustments made under subsection (g)(1) through (g)(2) above and Sections 148.160(f)(2) and 148.170(f)(2) from the aggregate DSH payment adjustment set by the Health Care Financing Administration (HCFA) in accordance with Public Law 102-234.

B) The State DSH Pool amount is then allocated to hospitals defined in Section 148.25(b)(6) that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of Medicaid inpatient utilization (adjusted based upon historical utilization and projected increases in utilization) to the sum of all qualifying hospitals Medicaid inpatient utilization.

C) The adjustment calculated in (g)(3)(C) above shall meet the limitation described in subsection (k)(4).

D) The adjustment calculated pursuant to subsection (g)(3)(B) above, for each hospital defined in Section 148.25(b)(6) that qualifies for DSH adjustments, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected ncreases in

utilization) to arrive at a per day adjustment. This amount is subject to the limitations described in subsection (k) of this Section. The adjustment described in this subsection shall be paid on a per diem basis and shall be applied to each Medicaid covered day of care provided.

h) Inpatient Adjuster for Children's Hospitals. For a children's hospital, as defined in subsection (a)(5) of this Section, the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 2.0.

i) Inpatient Adjustor County-Owned Hospitals.. For county-owned hospitals, defined in Section 148.25(b)(1)(A), the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 3.75.

j) Inpatient Adjustor for Hospitals Organized Under the University of Illinois Hospital Act. For a hospital and/or hospitals organized under the University of Illinois Hospital Act, as defined in Section 148.25(b)(1)(B), the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 3.75.

k) DSH Adjustment Limitations.

1) Hospitals that qualify for DSH adjustments under this Section shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues the provision of non-emergency obstetrical care (the provisions of this subsection shall not apply to those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4) or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987). In this instance, the adjustments calculated under subsections (g)(1) and (g)(2) shall cease effective on the date that the hospital discontinued the provision of such non-emergency obstetrical care.

2) Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for DSH payment adjustments based upon the requirements of this Section.

3) DSH Payment Adjustment ~~Cap~~. In accordance with Public Law 102-234, if the aggregate DSH payment adjustments calculated under this Section ~~exceed~~ do not meet the State's final DSH Allotment as determined by the Health Care Financing Administration (HCFA), DSH payment adjustments calculated under this Section shall be adjusted ~~in proportion~~ to meet the ~~lesser~~ State DSH Allotment. This adjustment shall first be applied to DSH payments made under subsection (g)(3) above. If further adjustments are necessary, then DSH payments made under

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subsection (g)(2) above shall be adjusted, with the DSH payments made under subsection (g)(1) being adjusted last.

4) Omnibus Budget Reconciliation Act of 1993 (OBRA'93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospitals' disproportionate share payments shall be made if the sum of Medicaid payments (inpatient, outpatient, and disporportionate share) made to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. The adjustments shall reduce disproportionate share spending until the costs and spending (described in the previous sentence) are equal or until the disproportionate share payments are reduced to zero. In this calculation, persons without insurance costs do not include contractual allowances.

5) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's Medicaid inpatient utilization rate, as defined in subsection (1)(5), is less than one percent.

1) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

1) "Base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993 DSH determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994 DSH determination year, etc.

2) "DSH determination year" means the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

3) "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in subsection (c)(3) of this Section. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

4) "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (1)(7) below, provided by all Medicaid-participating Illinois hospitals

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providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (1)(9) below, for all such hospitals. That information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.

5) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a et seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in subsection (c)(3) of this Section. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

6) "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (1)(7) below, provided by a Medicaid-partcipating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a et. seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (1)(9) below provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.

7) "Medicaid (Title XIX) obstetrical inpatient days" means hospital inpatient days which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with an ICD-9-CM principal diagnosis code within the ranges of 650 and 669 which result in

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childbirth, and specifically excludes Medicare/Medicaid crossover claims.

8) "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).

9) "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (1)(4) and (1)(6) above, means hospital inpatient days, excluding days for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

10) "Medicaid obstetrical inpatient utilization rate base year" means, for example, state fiscal year 1992 for the October 1, 1993, DSH determination year; state fiscal year 1993 for the October 1, 1994, DSH determination year, etc.

(Source: Emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days)

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1) Heading of the Part: Medical Payment

2) Code Citation: 89 Ill. Adm. Code 140

3) Section Numbers: Emergency Action:

140.80 Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, par. 12-13) [305 ILCS 5/12-13]

5) Effective Date of Amendments: March 1, 1995

6) If these Emergency Amendments are to expire before the end of the 150-day period, please specify the date on which it is to expire: Not Applicable

7) Date Filed in Agency's Principal Office: March 1, 1995

8) Reason for Emergency: These emergency amendments are being filed in conjunction with an emergency rulemaking at 89 Ill. Adm. Code 148 which enables Illinois to maximize federal financing benefits to hospitals as permitted by the State's federal disproportionate share (DSH) spending limitations. Effective March 1, 1995, facilities operated by the Department of Mental Health and Developmental Disabilities (DMHDD) are eligible to qualify for DSH hospital adjustments. Since State operated facilities providing hospital services do not participate in the provider assessment program, and such facilities are now considered as providers of hospital services qualifying for DSH adjustments, these emergency amendments to Section 140.80 are required to specifically exempt DMHDD facilities from responsibility under the hospital assessment program. Immediate implementation of these amendments will ensure that access to necessary health care in DMHDD facilities is maintained and expanded.

9) Complete Description of the Subjects and Issues Involved: Effective March 1, 1995, facilities operated by the Department of Mental Health and Developmental Disabilities (DMHDD) will be eligible to qualify for disproportionate share (DSH) hospital adjustments. The Department is initiating this action through an emergency rulemaking at 89 Ill. Adm. Code 148 to maximize federal financing benefits to Illinois as permitted by the State's federal DSH spending limitations.

These emergency amendments to Section 140.80 are required to exempt facilities operated by DMHDD from the hospital provider assessment program. State operated facilities providing hospital services do not participate in the provider assessment program because their condition as State funded entities would not permit an increase in federal monies through the assessment process. However, since the DMHDD facilities are now considered as providers of hospital services which qualify for DSH

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adjustments, the facilities must be specifically exempted from the hospital assessments imposed under Section 140.80.

The emergency amendments will not result in any changes in Department spending.

10) Are there any Proposed Amendments pending to this Part? Yes

Sections	Proposed Action	Illinois Register Citation
140.11	Amendment	January 13, 1995 (19 Ill. Reg. 165)
140.12	Amendment	January 13, 1995 (19 Ill. Reg. 165)
140.400	Amendment	February 10, 1995 (19 Ill. Reg. 1200)
140.413	Amendment	July 8, 1994 (18 Ill. Reg. 10637)
140.435	Amendment	February 10, 1995 (19 Ill. Reg. 1200)
140.523	Amendment	January 13, 1995 (19 Ill. Reg. 165)
140.645	Amendment	December 16, 1994 (18 Ill. Reg. 17865)

11) Statement of Statewide Policy Objectives: These emergency amendments do not affect units of local government.

12) Information and questions regarding these Emergency Amendments shall be directed to:

Joanne Jones
Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, Illinois 62762
(217) 524-3215

The full text of the Emergency Amendments begins on the next page:

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CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 140
MEDICAL PAYMENT

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140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
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140.958 Admitting and Clinical Privileges (Recodified)
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AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 6503-1 et seq.) [20 ILCS 2215/Art. 3] and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13) [305 ILCS 5/Arts. 3, 4, 5, 6, 7 and 12-13].

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677,

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effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg.7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1961, effective January 1, 1988, for a maximum of 150 days; amended at 12

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Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1998, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990;

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emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; Section 140.569 withdrawn at 15 Ill. Reg. 1174; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; emergency amendment suspended effective October 12, 1993; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended, effective November 15, 1994; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2932, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days.

SUBPART C: PROVIDER ASSESSMENTS

Section 140.80 Hospital Provider Fund
EMERGENCY

a) Purpose and Contents
   1) The Hospital Provider Fund ("Fund") was created in the State Treasury upon enactment of Public Act 87-861 and Public Act 88-88. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.
   2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-861, as amended by Public Act 88-88.
   3) The Fund shall consist of:
      A) All monies collected or received by the Department under subsection (b) below;
      B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;
      C) Any interest or penalty levied in conjunction with the administration of the Fund;
      D) All other monies received for the Fund from any other source, including interest earned thereon;
      E) All monies transferred from the Hospital Services Trust Fund; and
      F) All monies transferred from the Tobacco Products Tax Act.
b) Provider Assessments

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Beginning on July 1, 1993, and ending on June 30, 1994, an assessment is imposed upon each hospital provider in an amount equal to 1.88% of the provider's adjusted gross hospital revenue, as described in subsection (1)(l) of this Section, for the most recent calendar year ending before the beginning of that State fiscal year. An assessment is imposed upon each hospital provider for the fiscal year beginning on July 1, 1994, and ending on June 30, 1995, in an amount equal to the provider's adjusted gross hospital revenue, as described in subsection (1)(l) of this Section, for the most recent calendar year ending before the beginning of that State fiscal year multiplied by the Provider's Savings Rate, as described in subsection (1)(10) of this Section. The Department reserves the right to audit the reported data. The Department shall notify hospital providers of the Provider's Savings Rate by mailing a notice to each provider's last known address as reflected by the records of the Department.

c) Payment of Assessment Due

1) The assessments imposed in subsection (b) above shall be due and payable in quarterly installments, each equalling one-fourth of the assessment for the year, on September 30, December 31, March 31, and May 31 of the year. Assessment payments postmarked on the due date will be considered as paid on time.

2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) After December 31 of each year, and on or before March 31 of the succeeding year, every hospital provider subject to an assessment under subsection (b) above shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross hospital revenue from the calendar year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the next July 1. If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, a separate report shall be filed for each hospital. In the case of a hospital provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

2) If the hospital provider fails to file its report for a State fiscal year on or before the due date of the report, there shall be, unless waived by the Department for reasonable cause, added to the assessment imposed in subsection (b) above a penalty assessment equal to 25% of the assessment imposed for the year.

3) Every hospital provider subject to an assessment under subsection (b) above shall keep records and books that will permit the determination of adjusted gross hospital revenue on a calendar

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year basis. All such books and records shall be maintained for a minimum of three years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsections (d)(5) or (6) below, an amended assessment report must be filed within 30 calendar days of the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

5) Submission of Financial Audit Statements. All hospital providers are required to submit a copy of all financial statements audited by an external, independent auditor, to the Department within 30 days after the close of such externally performed financial audits. If the hospital's year end does not coincide with the December 31 ending date for the assessment report, the hospital must submit all financial audits covering the assessment report period. An amended assessment report must accompany such external financial audit statements if the data submitted on the initial assessment report changes based upon the findings of such external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.

6) Reconsideration of Adjusted Assessment. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a hospital provider, the hospital provider may request a review or reconsideration of the adjusted assessment within 30 days after the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. If a hospital provider ceases to conduct, operate, or maintain a hospital for which the person is subject to assessment under subsection (b) above, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) by a fraction, the numerator of which is the number of days

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in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. The person shall file a final, amended report with the Department not more than 30 calendar days after the cessation, reflecting the adjustment, and shall pay with the final return the assessment for the year as so adjusted, to the extent not previously paid.

2) Commencing of business during the fiscal year in which the assessment is being paid. A hospital provider who commences conducting, operating, or maintaining a hospital for which the person is subject to assessment under subsection (b) above, shall file an initial report for the State fiscal year in which the commencement occurs within 30 calendar days thereafter and shall pay the assessment under subsection (d) above as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.

3) Partial Calendar Year Operation Adjustment. For a hospital provider that did not conduct, operate, or maintain a hospital throughout the entire calendar year reporting period, the assessment for the following State fiscal year shall be annualized based on the provider's actual revenues for the portion of the reporting period the hospital was operational (dividing adjusted gross hospital revenue by the number of days the hospital was in operation and then multiplying the amount by 365). Revenues realized by a prior provider from the same hospital during the calendar year shall be used in the annualization equation, if available.

4) Change in Ownership and/or Operations. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rest on the hospital provider currently operating or maintaining the hospital regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liability incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any hospital that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for

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reasonable cause, a penalty equal to 5% of the amount of the installment not paid on or before the due date, plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100% of the installment amount not paid on or before the due date.

2) Within 45 days from the due date, the Department may begin recovery actions against delinquent hospitals participating in the Medicaid Program. Payments may be withheld from the hospital until the entire assessment, including any penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached or if a hospital fails to comply with an agreement, the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the hospital's future payments from the Department. The provider may appeal this recoupment in accordance with Department rules contained in 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) above will continue to accrue during the recoupment process. Recoupment proceedings against the same hospital two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 45 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the hospital does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months after the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Hospitals

The Director may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

1) the State delays payments to hospitals due to problems related to State cash flow, or

2) a cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a significant number of hospitals will be unable to obtain a loan to pay the assessment.

h) Delayed Payment - Individual Hospitals

In addition to the provisions of subsection (g) above, the Director may delay assessments for individual hospitals that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment

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was to have been received by the Department as described in subsection (c) above.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions may be made only to qualified hospitals who meet all of the following requirements:

A) the provider has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1) and (f)(2) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a provider which are unrelated to Department technical system problems and which result in extensive financial problems to a facility, adversely impacting on its ability to serve its clients.

B) the provider serves a significant number of clients under the medical assistance program. "Significant" in this instance means:

i) a hospital that serves a significant number of clients under the medical assistance program; significant in this instance means that the hospital qualifies as a disproportionate share hospital under 89 Ill. Adm. Code 148.120(a)(1) through 148.120(a)(5); or qualifies as a Medicare DSH hospital under the current federal guidelines.

ii) a government-owned facility, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.

iii) a hospital which has filed for Chapter 11 bankruptcy, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.

C) the provider must file a delay of payment request as defined under subsection (h)(3)(A) below, and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

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i) the ratio of current assets divided by current liabilities is greater than 2.0.

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.

D) the provider must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institution such as a commercial bank. The denial must be 90 days old or less.

E) the provider must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver as described in subsection (h)(5) that shall be due from the provider as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement; and

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signature's knowledge.

vi) such other terms and conditions that may be required by the Department.

2) A hospital which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, providers must submit their request in writing

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(telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received as follows: delayed payment requests for installments due on September 30 of the year must be received on or before September 10 of the year; delayed payment requests for installments due on December 31 of the year must be received on or before December 10 of the year; delayed payment requests for installments due on March 31 of the year must be received on or before March 11 of the year; and delayed payment requests for installments due on May 31 of the year must be received on or before May 10 of the year. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) of this Section, a denial of application to borrow the assessment as defined in subsection (h)(1)(D) of this Section and an explanation of the risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the provider.

B) The hospital shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the provider's request for institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the provider fails to meet all of the terms and conditions of the agreement. In the event the provider fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such

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penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above, is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B) above. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delayed payment agreement. The waiver of penalties described in subsection (h)(4) shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions

Pursuant to Section 5A-7 of P.A. 86-861, to the extent practicable, the Department shall administer and enforce P.A. 86-861, as amended by P.A. 88-88, and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Exemptions

1) A rural hospital, as defined in subsection (l)(11) below, shall be exempt from the assessment imposed under subsection (b), unless the exemption is a judged to be unconstitutional or otherwise invalid, in which case the provider shall pay the assessment imposed under subsection (b) above.

2) A hospital provider which is a county with a population of more than 3,000,000 that makes intergovernmental transfer payments as provided in Section 15-3 of P.A. 87-861, as amended by P.A. 88-85 and P.A. 88-88, shall be exempt from the assessment imposed by subsection (b) above, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital shall pay the assessment imposed by subsection (b) above for all assessment periods beginning on or after July 1, 1992, and the assessment so paid shall be creditable against the intergovernmental transfer payments.

3) The Department is authorized to enter into an interagency agreement with a hospital organized under the University of Illinois Hospital Act exempt from the assessment imposed under

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subsection (b) of this Section, to make intergovernmental transfer payments to the Department. These payments shall be deposited into the General Revenue Fund.

4) The Department is also authorized to enter into agreements with publicly owned or operated hospitals not described in subsections (j)(1) through (j)(3) above to make intergovernmental transfer payments to the Department. These payments shall be deposited into the Hospital Provider Fund.

5) Facilities operated by the Department of Mental Health and Disabilities which are accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO), shall be exempt from the assessment imposed by subsection (b) of this Section.

k) Nothing in P.A. 88-88 shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before the effective date of P.A. 88-88.

l) Definitions

As used in this Section, unless the context requires otherwise:

1) "Adjusted gross hospital revenue" means the hospital provider's total gross patient charges less Medicare contractual allowances, but does not include gross patient revenue (and the portion of any Medicare contractual allowance related thereto) from skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act. Revenue generated from swing beds, as described in subsection (l)(12) below, is considered to be part of the provider's gross hospital revenue. Revenue not related to patient care, such as investment income, gift shop, cafeteria, or parking lot revenue, is not considered as patient revenue. Adjusted gross hospital revenue must be reported on an accrual basis for the assessment reporting period. All patient revenue accrued during the assessment reporting period must be included even though reimbursement may occur after the assessment reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the hospital's last two cost reports.

2) "Cigarette Tax Contribution" is the sum of the total amount deposited in the Hospital Provider Fund in State fiscal year 1994 pursuant to Section 2(a) of the Cigarette Tax Act, plus the total amount deposited in the Hospital Provider Fund in State fiscal year 1994 pursuant to Section 5A-3(c) of Public Act 88-88.

3) "Department" means the Illinois Department of Public Aid.

4) "Fund" means the Hospital Provider Fund.

5) "Hospital" means an institution, place, building, or agency located in this State that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the State in which it is located.

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6) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

7) "Intergovernmental transfer payment" means the payments established under Section 15-3 of P.A. 87-861, as amended by P.A. 88-85 and P.A. 88-88, and includes without limitation payments payable under that Section for July, August and September of 1992.

8) "Maximum Section 5A-2 Contribution" is the total amount of tax imposed by Section 5A-2 of Public Act 88-88 in State fiscal year 1994 on providers subject to the assessment imposed by subsection (b) above; multiplied by a fraction the numerator of which is adjusted gross hospital revenues reported to the Department by providers subject to the assessment imposed by subsection (b) for State fiscal year 1994 and the denominator of which is adjusted gross hospital revenues reported to the Department by providers subject to the assessment imposed by subsection (b) for State fiscal year 1993.

9) "Medicare Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by Medicare, as appropriate, pursuant to agreements between the hospital and the Health Care Financing Administration.

10) "Provider's Savings Rate" is 1.88% multiplied by a fraction, the numerator of which is the Maximum Section 5A-2 Contribution minus the Cigarette Tax Contribution, and the denominator of which is the Maximum Section 5A-2 Contribution.

11) "Rural hospital" means a hospital that is either located outside a metropolitan statistical area, or is located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and has a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health. The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993). Appeals of the geographic designation of hospital provider shall be in accordance with 89 Ill. Adm. Code 148.310(m).

12) "Swing-beds" means those beds for which a hospital provider has been granted an approval from the federal Health Care Financing Administration to provide post-hospital extended care services

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(42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).

(Source: Emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days)

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1) Heading of the Part: Property Tax Code

2) Code Citation: 86 Ill. Adm. Code 110

3) Section Numbers: Emergency Action:

110.190	Amendment
110.192	New Section

4) Statutory Authority: 35 ILCS 200/18-245 and 35 ILCS 220/18-249

5) Effective Date of Amendments: March 1, 1995

6) If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire: This Emergency Amendment will remain in effect for the 150-day period.

7) Date filed in Agency's Principal Office: March 1, 1995

8) Reason for Emergency: Effective February 12, 1995, Public Act 89-1 revised the Property Tax Extension Limitation Law to expand it into Cook County. That Public Act also created the One-Year Property Tax Extension Limitation Law. Since the amendatory Act is effective immediately, it must be implemented immediately by assessors.

9) A Complete Description of the Subjects and Issues Involved: The method of implementation of both property extension limitation laws.

10) Are there any amendments to this Part pending: Yes

Section Numbers	Proposed Action	IL Register Citation
110.195	New Section	3/3/95, 19 Ill. Reg. 2476

11) Statement of Statewide Policy Objectives: This rulemaking neither imposes a State mandate, nor modifies an existing mandate.

12) Information and questions regarding this amendment shall be directed to:

Jerry Lanter
Senior Counsel - Property Tax
Illinois Department of Revenue
Office of General Counsel
101 West Jefferson, 5-500
Springfield, Illinois 62794
Phone: (217) 782-6336

The full text of the Emergency Amendment(s) begins on the next page:

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TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 110
PROPERTY TAX CODE

Section
110.101 Railroads
110.105 Non-carrier Real Estate of Railroads
110.110 Procedures for Assessment of Pollution Control Facilities and Low Sulphur Dioxide Emission Coal Fueled Devices
110.115 Exemption Proceedings
110.120 Oil Right Lessees and Producers
110.125 Reports to be Filed with the Department
110.130 Hearings and Records of County Assessor, Supervisor of Assessments or Board of Assessors
110.135 Review of Assessments - Counties of 1,000,000 or More
110.140 Board of Review Procedures and Records - Counties of Less than 1,000,000
110.141 Farmland Factor Review Procedures (Repealed)
110.145 Practice and Procedure
110.150 Records Reproduction
110.155 Appointment of Board of Review Members After Examination
110.160 Multi-township Assessment Districts
110.165 Farmland Assessment Review Procedures
110.170 Assessors' Bonus
110.175 Equalization by Supervisor of Assessments
110.180 Supervisor of Assessments Examination
110.190 Property Tax Extension Limitation
EMERGENCY
110.192 One-Year Property Tax Extension Limitation
EMERGENCY
110.195 Senior Citizens Tax Freeze Homestead Exemption

AUTHORITY: Implementing the Property Tax Code (See P.A. 88-455) [35 ILCS 200] and authorized by Section 39b35 of the Civil Administrative Code of Illinois [20 ILCS 2505/39b35].

SOURCE: Adopted June 1, 1940; amended at 5 Ill. Reg. 2999, effective March 11, 1981; amended at 5 Ill. Reg. 5888, effective May 26, 1981; amended at 6 Ill. Reg. 9707, effective July 27, 1982; amended at 6 Ill. Reg. 14564, effective November 5, 1982; codified at 7 Ill. Reg. 5886; amended at 8 Ill. Reg. 24285, effective December 5, 1984; amended at 9 Ill. Reg. 159, effective December 26, 1984; amended at 9 Ill. Reg. 12022, effective July 24, 1985; amended at 10 Ill. Reg. 11284, effective June 16, 1986; amended at 10 Ill. Reg. 15125, effective September 2, 1986; amended at 11 Ill. Reg. 19675, effective November 23, 1987; amended at 11 Ill. Reg. 20972, effective December 11, 1987; amended at 12 Ill. Reg. 14346, effective August 29, 1988; amended at 13 Ill. Reg. 6803, effective

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April 12, 1989; amended at 13 Ill. Reg. 7469, effective May 2, 1989; amended at 15 Ill. Reg. 3522, effective February 21, 1991; emergency rule added at 15 Ill. Reg. 14297, effective October 1, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 2624, effective February 4, 1992; emergency amendment at 17 Ill. Reg. 22584, effective January 1, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 15618, effective October 11, 1994; emergency amendment at 19 Ill. Reg. 2476, effective February 17, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 3555, effective MAR 01 1995, for a maximum of 150 days.

Section 110.190 Property Tax Extension Limitation
EMERGENCY

a) New Property
1) New property as defined in Section ~~1-5~~ 18-185 of the Property Tax ~~Extension--Limitation--Act--(P.A.--87-17)~~ Code includes only new improvements or additions to existing improvements on any parcel of real property that increased the assessed value of that real property during the levy year. It does not include maintenance and repair. The amount of value shall be limited to the actual value added by the new improvement.
~~2) For the 1991 levy year, the dollar amount of new property for each taxing district subject to the Property Tax Extension Limitation Act shall be reported to the county clerk by the supervisor of assessments within 20 days of the adjournment of the Board of Review or by the county assessor within 10 days of the adjournment of the Board of Appeals. For the 1991 levy year, the supervisors of assessments and county assessor shall use assessment records, tax codes and other available means to accurately report the amount of new property. The value reported to the county clerk must be the final value for the new property after final Board of Review or Board of Appeals action.~~
32) For the 1992 and subsequent levy years, the township assessors, multi-township assessors, supervisors of assessments, county assessors, Boards of Review and Board of Appeals shall enter their assessments of new property located in taxing districts subject to the Property Tax Extension Limitation ~~Act~~ Law in separate columns specifically designated for new property in the assessment books.
43) The following special situations are new property under the circumstances described:
A) New improvements or additions to existing improvements that increased the assessed value of property during the levy year in an Enterprise Zone comprise new property for that levy year only to the extent that taxes are not abated on this new property.
B) Property which receives a prorated assessment under Section ~~27a~~ 9-180 of the ~~Revenue--Act--of--1939~~ Property Tax Code

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because of the construction of new or added buildings, structures or other improvements which were substantially completed, initially occupied or initially used during the levy year is new property and the amount of new property for that levy year is the amount of the equalized prorated assessment. When this property receives the full assessment in the next levy year, the difference between the equalized prorated assessment and the next levy year's equalized assessment which is due to the new or added buildings, structures or other improvements which were substantially completed or initially occupied or initially used is the amount of new property for the next levy year.

54) New property does not include:

A) Property which in the prior year received a prorated assessment as damaged, uninhabitable property under Section ~~27a~~ 9-180 of the ~~Revenue Act~~ Property Tax Code or as damaged property in a disaster area under Section ~~14e.01~~ 13-5 of the ~~Revenue Act~~ Property Tax Code ~~(disaster area)~~. However, there are three exceptions:

i) If new improvements are added to the parcel, these new improvements are new property.

ii) If square footage is added to the structure, this addition to the structure is new property.

iii) If the property was completely destroyed and rebuilt, then the completely rebuilt structure is new property.

B) Property on which the assessment has increased under Section ~~20j-3~~ 10-50 of the ~~Revenue Act of 1939~~ Property Tax Code (phaseout of historic residence assessment) and property on which the assessment under Section ~~20j-2~~ 10-45 (historic residence assessment) has been revoked.

C) Property which was exempt during the prior levy year and reclassified and assessed as non-exempt for the levy year.

D) Property which was exempt on January 1 of the levy year and reclassified and assessed as non-exempt during the levy year.

E) That portion of property receiving the homestead improvement exemption under ~~Sections 19.23-2 or 19.23-3~~ Section 15-180 of the ~~Revenue Act of 1939~~ Property Tax Code. However, the additional assessment attributable to the removal or expiration of the homestead improvement exemption is new property in the year of the removal or expiration. The value of the new property shall be the most recent assessed value of that portion for which the homestead improvement exemption has expired or is removed times the equalization factor.

F) Omitted property assessed under Section ~~22e~~ 9-265 of the ~~Revenue Act~~ Property Tax Code.

G) New improvements or additions to existing improvements on

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property in a redevelopment project area, as defined in the Tax Increment Allocation Redevelopment Act [65 ILCS 5/11-74.4] or the Industrial Jobs Recovery Law [65 ILCS 5/11-74.6], that increased the assessed value of that property during the levy year ~~in a Tax Increment Financing District~~.

H) All increases in the assessment of land.

b) Levies Subject to Annual Backdoor Referendum

1) Section ~~1-7(a)~~ 18-190 of the Property Tax ~~Extension Limitation Act~~ Code requires that a new rate or a rate increase be approved at a direct referendum before it becomes effective for an affected taxing district.

2) Rates required to extend taxes on levies subject to a backdoor referendum in each year there is a levy are not new rates or rate increases under Section ~~1-7(a)~~ 18-190 if a levy has been made for the fund in one or more of the preceding three levy years.

3) If a higher statutory rate limit for the fund is enacted and a levy causes the rate to be above the previous statutory rate limit, this is a rate increase under Section ~~1-7(a)~~ 18-190 which must be submitted to direct referendum in order to become effective.

4) When a levy for a specific fund is made for the first time, this is a new rate under Section ~~1-7(a)~~ 18-190 without regard to whether it is a new statutory authorization.

c) Computation of the Limiting Rate

1) When computing the limiting rate, the incremental equalized assessed value in a tax increment financing district is not included in the current year's equalized assessed value of all real property in the territory under the jurisdiction of the taxing district during the prior levy year.

2) When computing the limiting rate, the equalized assessed value in an Enterprise Zone is not included in the current year's equalized assessed value of all real property in the territory under the jurisdiction of the taxing district during the prior levy year to the extent that taxes are abated on this property.

~~3) When adjusting the limiting rate for a disconnection, the current levy year's equalized assessed value of property which was under the jurisdiction of the taxing district during the prior levy year, but which is part of the disconnected territory, is subtracted from the denominator of the limiting rate.~~

(Source: Emergency amendment at 19 Ill. Reg. 3555, effective MAR 01 1995, for a maximum of 150 days)

Section 110.192 One-Year Property Tax Extension Limitation
EMERGENCY

a) New Property

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1) New property as defined in Section 18-246 of the Property Tax Code includes only new improvements or additions to existing improvements on any parcel of real property that increased the assessed value of that real property during the levy year. It does not include maintenance and repair. The amount of value shall be limited to the actual value added by the new improvement.

2) For the 1994 levy year, the dollar amount of new property for each taxing district subject to the One-Year Property Tax Extension Limitation Law shall be reported to the county clerk by the supervisor of assessments within 20 days after the adjournment of the Board of Review. In Cook County, new property must be reported to the county clerk by the County Assessor within 10 days after the adjournment of the Board of Appeals. For the 1994 levy year, the county assessor must use assessment records, tax codes and other available means to accurately report the amount of new property. The value reported to the county clerk must be the final value for the new property after final action by the Board of Review or Board of Appeals.

3) The following special situations are new property under the circumstances described:

A) New improvements or additions to existing improvements that increased the assessed value of property during the levy year in an Enterprise Zone comprise new property for that levy year only to the extent that taxes are not abated on this new property.

B) Property which receives a prorated assessment under Section 9-180 of the Property Tax Code because of the construction of new or added buildings, structures or other improvements which were substantially completed, initially occupied or initially used during the levy year is new property and the amount of new property for that levy year is the amount of the equalized prorated assessment. When this property receives the full assessment in the next levy year, the difference between the equalized prorated assessment and the next levy year's equalized assessment which is due to the new or added buildings, structures or other improvements which were substantially completed or initially occupied or initially used is the amount of new property for the next levy year.

4) New property does not include:

A) Property which in the prior year received a prorated assessment as damaged, uninhabitable property under Section 9-180 of the Property Tax Code or as damaged property in a disaster area under Section 13-5 of the Property Tax Code. However, there are three exceptions:

i) If new improvements are added to the parcel, these new improvements are new property.

ii) If square footage is added to the structure, this addition to the structure is new property.

iii) If the property was completely destroyed and rebuilt, then the completely rebuilt structure is new property.

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B) Property on which the assessment has increased under Section 10-50 of the Property Tax Code (phaseout of historic residence assessment) and property on which the assessment under Section 10-45 (historic residence assessment) has been revoked.

C) Property which was exempt during the prior levy year and reclassified and assessed as non-exempt for the levy year.

D) Property which was exempt on January 1 of the levy year and reclassified and assessed as non-exempt during the levy year.

E) That portion of property receiving the homestead improvement exemption under Section 15-180 of the Property Tax Code. However, the additional assessment attributable to the removal or expiration of the homestead improvement exemption is new property in the year of the removal or expiration. The value of the new property shall be the most recent assessed value of that portion for which the homestead improvement exemption has expired or is removed times the equalization factor.

F) Omitted property assessed under Section 9-265 of the Property Tax Code.

G) New improvements or additions to existing improvements on property in a redevelopment project area, as defined in the Tax Increment Allocation Redevelopment Act [65 ILCS 5/11-74.4] or the Industrial Jobs Recovery Law [65 ILCS 5/11-74.6], that increased the assessed value of that property during the levy year.

H) All increases in the assessment of land.

b) Computation of the Limiting Rate

1) When computing the limiting rate, the incremental equalized assessed value in a tax increment financing district is not included in the current year's equalized assessed value of all real property in the territory under the jurisdiction of the taxing district during the prior levy year.

2) When computing the limiting rate, the equalized assessed value in an Enterprise Zone is not included in the current year's equalized assessed value of all real property in the territory under the jurisdiction of the taxing district during the prior levy year to the extent that taxes are abated on this property.

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(Source: Emergency rule at 19 Ill. Reg. 3555, effective MAR 0 1 1995, for a maximum of 150 days)

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LISTING OF DERIVED WATER QUALITY CRITERIA

Pursuant to 35 Ill. Adm. Code 302.Subpart F, the following water quality criteria have been derived as follows. This listing includes only the water quality criteria that have been used during the period November 1, 1994 through January 31, 1995.

A cumulative listing of criteria as of July 31, 1993 was published in 17 Ill. Reg. 18904, October 29, 1993. Listings of criteria used during subsequent three month periods were published in 18 Ill. Reg. 318, January 7, 1994; 18 Ill. Reg. 4457, March 18, 1994; 18 Ill. Reg. 8734, June 10, 1994; 18 Ill. Reg. 14166, September 9, 1994; and 18 Ill. Reg. 17770, December 9, 1994.

Chemical: Acenaphthene CAS #83-32-9
Acute criterion: 124 ug/l Chronic criterion: 9.9 ug/l
Date criteria derived: November 14, 1991
Applicable waterbodies:

Not used during this period.

Chemical: Acetone CAS #67-64-1
Acute criterion: 1,530 mg/l Chronic criterion: 122 mg/l
Date criteria derived: May 25, 1993
Applicable waterbodies:

Not used during this period.

Chemical: Acetonitrile CAS #75-05-8
Acute criterion: 375 mg/l Chronic criterion: 30 mg/l
Date criteria derived: December 7, 1993
Applicable waterbodies:

Not used during this period.

Chemical: Acrylonitrile CAS #107-13-4
Acute criterion: 910 ug/l Chronic criterion: 73 ug/l
Human health criterion (HNC): 0.21 ug/l
Date criteria derived: November 13, 1991
Applicable waterbodies:

Not used during this period.

Chemical: Anthracene CAS #120-12-7
Human health criterion (HTC): 35 mg/l

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LISTING OF DERIVED WATER QUALITY CRITERIA

Date criteria derived: August 18, 1993
Applicable waterbodies:

Not used during this period.

Chemical: Benzene CAS #71-43-2
Acute criterion: 5,200 ug/l Chronic criterion: 416 ug/l
Human health criterion (HNC): 21 ug/l
Date criteria derived: August 15, 1990
Applicable waterbodies:

Not used during this period.

Chemical: Benzo(a)anthracene CAS #56-55-3
Human health criterion (HNC): 0.01 ug/l
Date criteria derived: August 10, 1993
Applicable waterbodies:

Not used during this period.

Chemical: Benzo(a)pyrene CAS #50-32-8
Human health criterion (HNC): 0.01 ug/l
Date criteria derived: August 10, 1993
Applicable waterbodies:

Not used during this period.

Chemical: Benzo(b)fluoranthene CAS # 205-99-2
Human health criterion (HNC): 0.01 ug/l
Date criteria derived: August 10, 1993
Applicable waterbodies:

Not used during this period.

Chemical: Benzo(k)fluoranthene CAS #207-08-9
Human health criterion (HNC): 0.01 ug/l
Date criteria derived: August 10, 1993
Applicable waterbodies:

Not used during this period.

ENVIRONMENTAL PROTECTION AGENCY

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LISTING OF DERIVED WATER QUALITY CRITERIA

Chemical: Carbon tetrachloride CAS #56-23-5
Acute criterion: 3,500 ug/l Chronic criterion: 280 ug/l
Human health criterion (HNC): 1.4 ug/l
Date criteria derived: June 18, 1993
Applicable waterbodies:

Not used during this period.

Chemical: Chlorobenzene CAS #108-90-7
Acute criterion: 993 ug/l Chronic criterion: 79 ug/l
Date criteria derived: December 11, 1991
Applicable waterbodies:

Not used during this period.

Chemical: Chloroform CAS #67-66-3
Acute criterion: 1,870 ug/l Chronic criterion: 150 ug/l
Human health criterion (HNC): 130 ug/l
Date criteria derived: October 26, 1992
Applicable waterbodies:

Not used during this period.

Chemical: Chrysene CAS #218-01-9
Human health criterion (HNC): 0.01 ug/l
Date criteria derived: August 10, 1993
Applicable waterbodies:

Not used during this period.

Chemical: 1,2-dichlorobenzene CAS #95-50-1
Acute criterion: 210 ug/l Chronic criterion: 16.8 ug/l
Date criteria derived: December 1, 1993
Applicable waterbodies:

Not used during this period.

Chemical: 1,3-dichlorobenzene CAS #541-73-1
Acute criterion: 500 ug/l Chronic criterion: 196 ug/l
Date criteria derived: July 31, 1991
Applicable waterbodies:

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Not used during this period.

Chemical: 1,2-dichloroethane CAS #107-06-2
Acute criterion: 24,900 ug/l Chronic criterion: 4,540 ug/l
Human health criterion (HNC): 23 ug/l
Date criteria derived: March 19, 1992
Applicable waterbodies:

Not used during this period.

Chemical: 1,1-dichloroethylene CAS #75-35-4
Acute criterion: 3,030 ug/l Chronic criterion: 242 ug/l
Human health criterion (HNC): 0.95 ug/l
Date criteria derived: March 20, 1992
Applicable waterbodies:

Not used during this period.

Chemical: 2,4-dichlorophenol CAS #120-83-2
Acute criterion: 631 ug/l Chronic criterion: 83.1 ug/l
Date criteria derived: November 14, 1991
Applicable waterbodies:

Not used during this period.

Chemical: 1,2-dichloropropane CAS #78-87-5
Acute criterion: 4,800 ug/l Chronic criterion: 380 ug/l
Date criteria derived: December 7, 1993
Applicable waterbodies:

Not used during this period.

Chemical: 1,3-dichloropropylene CAS #542-75-6
Acute criterion: 99 ug/l Chronic criterion: 7.9 ug/l
Date criteria derived: November 13, 1991
Applicable waterbodies:

Not used during this period.

Chemical: 4,6-dinitro-o-cresol = 2-methyl-4,6-dinitrophenol

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CAS #534-52-1
Acute criterion: 28.8 ug/l Chronic criterion: 2.3 ug/l
Date criteria derived: November 14, 1991
Applicable waterbodies:

Not used during this period.

Chemical: 2,4-dinitrophenol CAS #51-28-5
Acute criterion: 85.3 ug/l Chronic criterion: 4.07 ug/l
Date criteria derived: December 1, 1993
Applicable waterbodies:

Not used during this period.

Chemical: 2,6-dinitrotoluene CAS #606-20-2
Acute criterion: 1,910 ug/l Chronic criterion: 153 ug/l
Date criteria derived: February 14, 1992
Applicable waterbodies:

Not used during this period.

Chemical: Ethylbenzene CAS #100-41-4
Acute criterion: 216 ug/l Chronic criterion: 17.2 ug/l
Date criteria derived: August 15, 1990, revised May 17, 1991
Applicable waterbodies:

05120114-011/off storm sewer to Little Wabash River
07080101-006/off Jimmy Creek
07120004-011/off Diamond Lake
07140204-001/off Butter Creek
07140204-014/off Silver Creek

Chemical: Fluoranthene CAS #206-44-0
Human health criterion (HTC): 120 ug/l
Date criteria derived: August 10, 1993
Applicable waterbodies:

Not used during this period.

Chemical: Hexachlorobenzene CAS #118-74-1
Human health criterion (HNC): 0.00025 ug/l

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Date criteria derived: November 15, 1991
Applicable waterbodies:

Not used during this period.

Chemical: Hexachlorobutadiene CAS #87-68-3
Acute criterion: 34.5 ug/l Chronic criterion: 2.76 ug/l
Date criteria derived: March 23, 1992
Applicable waterbodies:

Not used during this period.

Chemical: Hexachloroethane CAS #67-72-1
Acute criterion: 381 ug/l Chronic criterion: 30.5 ug/l
Human health criterion (HNC): 2.9 ug/l
Date criteria derived: November 15, 1991
Applicable waterbodies:

Not used during this period.

Chemical: Isobutyl alcohol = 2-methyl-1-propapol
CAS #78-83-1
Acute criterion: 434 mg/l Chronic criterion: 34.8 mg/l
Date criteria derived: December 1, 1993
Applicable waterbodies:

Not used during this period.

Chemical: Methylene chloride CAS #75-09-2
Acute criterion: 17,200 ug/l Chronic criterion: 1,380 ug/l
Human health criterion (HNC): 340 ug/l
Date criteria derived: January 21, 1992
Applicable waterbodies:

Not used during this period.

Chemical: Methylethylketone CAS #78-93-3
Acute criterion: 322,000 ug/l Chronic criterion: 26,000 ug/l Date
criteria derived: July 1, 1992
Applicable waterbodies:

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Not used during this period.

Chemical: 4-methyl-2-pentanone CAS #108-10-1
Acute criterion: 46 mg/l Chronic criterion: 3.68 mg/l
Date criteria derived: January 13, 1992
Applicable waterbodies:

Not used during this peirod.

Chemical: Naphthalene CAS #91-20-3
Acute criterion: 670 ug/l Chronic criterion: 68 ug/l
Date criteria derived: November 7, 1991
Applicable waterbodies:

Not used during this period.

Chemical: Nitrobenzene CAS #98-95-3
Acute criterion: 15.4 mg/l Chronic criterion: 4.67 mg/l
Human health criterion (HTC): 0.52 mg/l
Date criteria derived: February 14, 1992
Applicable waterbodies:

Not used during this period.

tf Chemical: Pentachlorophenol
Acute criterion: 20 ug/l Chronic criterion: 13 ug/l
Date criteria derived: national criterion, September 1986
Applicable waterbodies:

Not used during this period.

Chemical: Phenanthrene CAS #85-01-8
Acute criterion: 46 ug/l Chronic criterion: 3.7 ug/l
Date criteria derived: October 26, 1992
Applicable waterbodies:

Not used during this period.

Chemical: Pyrene CAS #120-00-0
Human health criterion (HTC): 3,500 ug/l
Date criteria derived: December 22, 1992

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Applicable waterbodies:

Not used during this period.

Chemical: Tetrachloroethylene CAS #127-18-4
Acute criterion: 1,220 ug/l Chronic criterion: 152 ug/l
Date criteria derived: March 23, 1992
Applicable waterbodies:

Not used during this period.

Chemical: Tetrahydrofuran CAS #109-99-9
Acute criterion: 216,000 ug/l Chronic criterion: 17,300 ug/l Date criteria derived: March 16, 1992
Applicable waterbodies:

Not used during this period.

Chemical: Toluene CAS #108-88-3
Acute criterion: 8,080 ug/l Chronic criterion: 646 ug/l
Date criteria derived: August 16, 1990, revised May 17, 1991 and January 26, 1993
Applicable waterbodies:

05120114-011/offstorm sewer to Little Wabash River
07080101-006/offJimmy Creek
07120004-011/offDiamond Lake
07140204-001/offButter Creek

Chemical: 1,2,4-trichlorobenzene CAS #120-82-1
Acute criterion: 353 ug/l Chronic criterion: 69.2 ug/l
Date criteria derived: December 14, 1993
Applicable waterbodies:

Not used during this period.

Chemical: 1,1,1-trichloroethane CAS #71-55-6
Acute criterion: 4,910 ug/l Chronic criterion: 393 ug/l
Date criteria derived: October 26, 1992
Applicable waterbodies:

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LISTING OF DERIVED WATER QUALITY CRITERIA

Not used during this period.

Chemical: 1,1,2-trichloroethane CAS #79-00-5
Acute criterion: 19,000 ug/l Chronic criterion: 3,540 ug/l
Human health criterion (HNC): 12 ug/l
Date criteria derived: December 13, 1993
Applicable waterbodies:

Not used during this period.

Chemical: Trichloroethylene CAS #79-01-6
Acute criterion: 11,700 ug/l Chronic criterion: 940 ug/l
Date criteria derived: October 23, 1992
Applicable waterbodies:

Not used during this period.

Chemical: Xylenes CAS # 1330-20-7
Acute criterion: 1,500 ug/l Chronic criterion: 117 ug/l
Date criteria derived: August 23, 1990
Applicable waterbodies:

05120114-011/offstorm sewer to Little Wabash River
07080101-006/offJimmy Creek
07120004-011/offDiamond Lake
07140204-001/offButter Creek
07140204-014/offSilver Creek

For additional information concerning these criteria or the derivation process used in generating them, please contact:

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JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of February 28, 1995 through March 6, 1995, and have been scheduled for review by the Committee at its March 14, 1995 meeting. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rule should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Bldg., Springfield, IL 62706.

Second Notice Expires	Agency and Rule	Start of First Notice	JCAR Meeting
4/13/95	Department of Public Health, Subacute Care Hospital Demonstration Program Code (77 Ill Adm Code 270)	10/28/94 18 Ill Reg 15711	3/14/95
4/14/95	Department of Insurance, Repeal of Stated Value Policies (50 Ill Adm Code 937)	12/9/94 18 Ill Reg 17352	3/14/95

EXECUTIVE ORDERS NUMBER 2(1995)

AN EXECUTIVE ORDER CHANGING THE NAME OF THE DEPARTMENT OF CONSERVATION TO THE DEPARTMENT OF NATURAL RESOURCES AND TRANSFERRING TO IT CERTAIN POWERS OF THE DEPARTMENT OF MINES AND MINERALS, THE ABANDONED MINED LANDS RECLAMATION COUNCIL AND THE DIVISION OF WATER RESOURCES OF THE DEPARTMENT OF TRANSPORTATION

Article V. Section 11 of the Constitution of the State of Illinois authorizes the Governor to reassign functions among or reorganize executive agencies which are directly responsible to him in order to simplify the organizational structure of the Executive Branch, to improve accountability, to increase accessibility, and to achieve efficiency and effectiveness in operation;

For the purposes of organizational structure, this Executive Order changes the name of the Department of Conservation to the Department of Natural Resources and transfers to it various rights, powers, duties and functions of the Department of Energy and Natural Resources, the Department of Mines and Minerals, the Abandoned Mined Lands Reclamation Council and the Division of Water Resources of the Department of Transportation. The Executive Order also transfers certain oil overcharge functions of the Department of Energy and Natural Resources to the programs of the Department of Energy and Natural Resources to the Environmental Protection Agency and certain functions of the Department of Conservation related to the Lincoln Monument to the Historic Preservation Agency. This action will consolidate and centralize the programs and services now offered to citizens by these governmental bodies, resulting in more effective operation of these programs and services.

The effect of this Executive Order will be to create a new Department of Natural Resources, consolidate solid waste related programs in one agency, and merge energy and coal development programs with other economic development activities.

Both programmatic and administrative efficiencies will be achieved through the reorganization. The number of state agencies will be reduced; similar functions will be brought together; and duplication of services will be reduced. The result will be a more streamlined and more effective approach to protecting and managing the state's natural resources for the 21st century.

Creating a new Department of Natural Resources is a critical element of this reorganization plan. Natural resources are integral to the state's economy and quality of life. It is a priority of the Edgar administration to protect and restore Illinois' natural resources for present and future generations. We live in a complex and changing world, and if we are indeed going to protect our valuable natural resources far into the future, we must ensure that the natural resources management and policy decisions we make today

are based on a strong scientific foundation and the best information available. Furthermore, we need to take advantage of new communication and computer technologies to expand and enhance our dialogue with the public, so that they have easy access to both the scientificinformation and to the policy-making process itself.

By consolidating the Department of Conservation, Department of Mines and Minerals, Division of Water Resources, the Abandoned Mined Lands Reclamation Council, and the scientific divisions of the Department of Energy and Natural Resources into a new Department of Natural Resources, we will be better able to meet the natural resources related challenges of the 21st century. Furthermore, we will be better positioned to take a long-term and holistic approach to managing our natural resources from an ecosystem-based perspective.

One fundamental principle of the Department of Natural Resources will be that natural resources decisions are based on sound scientific principles. The scientific institutions being transferred to the Department of Natural Resources will play a vital role in achieving that objective. The Scientific Surveys and the Illinois State Museum have a long and distinguished record of service and are nationally recognized scientific institutions. They have been conducting research and providing valuable natural resource related data on a multitude of issues of over 100 years. Throughout their history they have served the people of Illinois by being a source of sound scientific information.

The three Scientific Surveys, Hazardous Waste Research and Information Center, Illinois State Museum, and ENR;s Office of Research and Planning will be transferred to the Department of Natural Resources in such a way so as to ensure the continued credibility and independence of their scientific missions. The funding sources, governing boards and board policies, and the long-standing relationship with the University of Illinois will all be preserved in order to maintain their important research, service, educational and advisory functions.

With the passage of the Solid Waste Management Act in 1986, the Department of Energy and Natural Resources and Illinois Environmental Protection Agency assumed significant new responsibilities related to waste reduction, recycling, and solid waste management in general. At the same time a major new funding source was established from fees on the disposal of solid waste. Since 1986 many more solid waste related bills have been passed and signed into the law that have added even more responsibilities to both EPA and ENR.

By consolidating the solid waste, programs in one agency, developing long-range goals and plans for the state's solid waste management programs will be more efficient. Accountability for expenditure of the funds will also be increased. In addition, administrative efficiencies will be achieved by having one agency responsible for overseeing expenditures from the solid waste management fund.

Over the years, the Department of Energy and Natural Resources has

provided grants, loans and technical assistance to: help local governments establish curbside recycling programs, stimulate new and expanded markets for recycled products, research and test new products made from recycled materials, carry out informational and educational programs, and establish composting facilities for yard wastes, a month other things. All of these efforts have been extremely valuable in meeting the objectives of reducing and recycling the waste we generate and will become a prominent focus of the Illinois EPA.

The administration fully intends to structure its solid waste management programs so that the hierarchy of preferred solid waste management practices established under the Solid Waste Management Act serves as a guiding principle. That hierarchy, in descending order of preference is: volume reduction at the source, recycling and reuse, combustion with energy recovery, combustion for volume reduction, and disposal in landfill facilities.

Another element of this reorganization is to transfer the energy conservation and alternative energy programs of ENR and the coal development and marketing programs of ENR into the Department of Commerce and Community Affairs. All of these programs have significant economic development components. By transferring them to DCCA, it will enhance their profile as significant economic development related activities of importance to the state of Illinois. Furthermore, DCCA currently administers a variety of energy related programs. Consolidating these programs in one agency will result in administrative efficiencies.

THEREFORE, pursuant to the power vested in me by Article V, Section 11 of the Illinois Constitution, I hereby order the following:

I. REDESIGNATION

A. The Illinois Department of Conservation is redesignated as the Illinois Department of Natural Resources.

B. The Director and Assistant Director of the Department of Conservation shall serve as the Director and Assistant Director of the Department of Natural Resources.

The Director and ASsistant Director of the Department of Natural Resources shall hold office from the dates of their respective appointments as Director and Assistant Director of the Department of Conservation until January 20, 1997, and until their successors are appointed and qualified. Thereafter, Section 13 of the Civil Administrative Code of Illinois shall control the terms of office.

Appointments to these offices shall be made by the Governor, by and with the advice and consent of the Senate. Acting Directors shall be appointed and vacancies filled in accordance with Section 12 of the Civil Administrative Code of Illinois, 20 ILCS 5/1 et seq., and the oath and bond requirements set forth in Sections 14 and 15 shall be applicable.

The Director of the Department of Natural Resources shall receive an annual salary as set by law for the Director of Conservation until such time

that the General Assembly and/or the Compensation Review Board establish a salary for the Director of the Department of Natural Resources. The Assistant Director of the Department of Natural Resources shall receive an annual salary as set by law for the Assistant Director of Conservation until such time that the General Assembly and/or the Compensation Review Board establish a salary for the Assistant Director of the Department of Natural Resources.

C. The Department of Natural Resources shall have within it an Office of Mines and Minerals which shall be responsible for the functions previously vested in the Department of Mines and Minerals and the Abandoned Mined Lands Reclamation Council and such other related functions and responsibilities as may be appropriate. The Office of Mines and Minerals shall be directed by a person who meets the qualifications established in Section 7.02 of the Civil Administrative Code of Illinois (Part 1). There shall be a manager of the Office of Mines and Minerals who meets the qualification established in Section 5/5.04 of the Civil Administrative Code of Illinois (Part 1) requiring that the person be "thoroughly conversant with the theory and practice of coal mining in the State of Illinois."

D. The Department of Natural Resources shall have within it an Office of Scientific Research and Analysis. Such Office shall contain within it a Natural History Survey division, a State Water Survey division, a State Geological Survey other related research functions and responsibilities as may be appropriate. The Board of Natural Resources and Conservation shall be retained as the governing board for the Scientific Surveys and Hazardous Waste Research and Information Center.

E. The Department of Natural Resources shall have within it a division consisting of the Illinois State Museum. The State Museum Board shall be retained as the governing board for the State Museum.

F. Whenever any provision of an Executive Order or any Act or section thereof transferred by this Executive Order provides for membership of the Director of Conservation, the Director of the Department of Energy and Natural Resources, the Director of the Department of Mines and Minerals, the Director of the Abandoned Mined Lands Reclamation Council and/or the Director of the Division of Water Resources of the Department of Transportation on any council, commission, board or other entity, the Director of the Department of Natural Resources or his/her designee(s) shall serve in that place. If more than one such director is required by law to serve on any council, commission, board or other entity, an equivalent number of representatives of the Department of Natural Resources shall so serve.

II. TRANSFER OF POWERS

A. THE DEPARTMENT OF NATURAL RESOURCES SHALL RETAIN THE POWERS OF THE DEPARTMENT OF CONSERVATION

The following rights, powers and duties by law vested in the Department of Conversation, or any office, division or bureau thereof by the following Acts or sections thereof, and all rights, powers and duties incidental thereto, are retained by the Department of Natural Resources:

1. Sub-paragraph (1) of paragraph (s) of section 3 of the Illinois Public Labor Relations Act. (5 ILCS 315/3(s)(1))

2. Paragraph 10 of the Oil And Gas Wells On Public Lands Act. (5 ILCS 615/10)

3. Paragraph 3 of the Treasurer As Custodian Of Funds Act. (15 ILCS 515/3)

4. Paragraph 3, 4, 5.09, 6.08 and 9.09 of the Civil Administrative Code Of Illinois (Part 1). (20 ILCS 5/3, 5/4, 5/5.09, 5/6.08 and 5/9.09)

5. Paragraph 51 of the Civil Administrative Code Of Illinois (Part 9). (20 ILCS 5/51)

6. Paragraph 40.35 of the Civil Administrative Code Illinois (Part 4). (20 ILCS 205/40.35)

7. Paragraphs 4 and 5 of the Agriculture Development Act. (20 ILCS 215/4 and 215/5)

8. Sub-paragraphs 18 and 20 of paragraph 4c of the Personnel Code. (20 ILCS 415/4c(18)(20))

9. Sub-paragraph j of paragraph 4 of the Rural Diversification Act. (20 ILCS 690/4(j))

10. Paragraphs 63a through 63b2.8 of the Civil Administrative Code Of Illinois (Part 13.5). (20 ILCS 805/63a et seq.)

11. Paragraphs .01 through 4 of the Forestry Cooperative Agreement Act. (20 ILCS 820/0.01 et seq.)

12. Paragraphs 0.01 and 1 of the Forest Land Exchange Act. (20 ILCS 825/0.01 and 1)

13. Paragraphs 1-1 through 4-1 of the Interagency Wetland Policy Act of 1989. (20 ILCS 830/1-1 et seq.)

14. Paragraphs 0.01 through 8 of the State Parks Act. (20 ILCS 835/0.01 et seq.)

15. Paragraphs 0.01 through 10 of the State Parks Designation Act. (20 ILCS 840 et seq.)

16. Paragraphs 0.01 and 1 of the State Park Audit Act. (20 ILCS 845/0.01 and 1)

17. Paragraphs 0.01 through 4 of the Illinois and Michigan Canal State Park Act. (20 ILCS 850/0.01 et seq.)

18. Paragraphs 0.01 through 2 of the Wild Or Scenic River Area Act. (20 ILCS 855/0.01 et seq.)

19. Paragraphs 0.01 through 6 of the Outdoor Recreation Resources Act. (20 ILCS 860/0.01 et seq.)

20. Paragraphs 0.01 and 1 of the Kaskaskia River Watershed Operation and Maintenance Act. (20 ILCS 870/0.01 and 1)

21. Paragraphs 0.01 and 1 of the Rend Lake Dam and Reservoir Operation and Maintenance Act. (20 ILCS 870/0.01 and 1)

22. Paragraphs 0.01 through 3 of the Firearms Training Act. (20 ILCS 875/0.01 et seq.)

23. Paragraphs 1 through 15 of the Conservation Foundation Act. (20 ILCS 880/1 et seq.)

24. Paragraph 1.04 of the Abandoned Mined Lands and Water Reclamation Act. (20 ILCS 1920/1.04)

25. Paragraphs 49.06f, 49028 and 49.29 of the Vivil Administrative Code of Illinois (Part 8.5). (20 ILCS 2505/49.06f, 2505/49.28 and 2505.49.29)

26. Paragraph 5 of the Department of Veterans Affairs Act. (20 ILCS 2805/5)

27. Paragraph 1 of the Capitol City Planning Commission Act. (20 ILCS 3920/1)

28. Paragraphs 6z-10, 8.11, 8.25c, 8.30, 8.34 and 8.35 of the State Fiance Act. (30 ILCS 105/6z-10, 105/8.11, 105/8.25c, 105/8.30, 105/8.34 and 105/8.35)

29. Paragraphs 1 through 8 of the Natural Heritage Fund Act. (30 ILCS 105/1 et seq.)

30. Paragraphs 1 through 4 of the Illinois Non-Game Wildlife Protection Act. (30 ILCS 155/1 et seq.)

31. Paragraph 2 of the Public Use Trust Act. (30 ILCS 160/2)

32. Paragraphs 3 and 8 of the State Parks Revenue Bond Act. (30 ILCS 380/3 and 380/8.)

33. Paragraph 4 of the State Vehicle Identification Act. (30 ILCS 610/4)

34. Paragraphs 1 through 7 of the Urban Forestry Assistance Act. (30 ILCS 735/1 et seq.)

35. Paragraph 1-3 of the Build Illinois Act. (30 ILCS 750/1-3)

36. Paragraphs 10-150, 10-167, 10-169 and 18-175 of the Property Tax Code. (35 ILCS 200/10-150, 200/10-167, 200/10-169and 200/18-175)

37. Paragraph 8 of the Motor Fuel Tax Law. (35 IlCS 505/8)

38. Paragraphs 14-103.5, 14-110 and 14-131 of the Illinois Pension Code (40 ILCS 5/14-103.5, 5/14-110 and 5/14-131)

39. Paragraphs 5-1062, 5-1062.1 and 5-30009 of the Counties Code. (55 ILCS 5/5-1062, 5/5-1062.1 and 5/5-30009)

40. Paragraph 23 of the Soil and Water Conservation Districts Act. (70 ILCS 405/23)

41. Paragraphs 4, 6, 10, 12 and 18 of the Conservation District Act. (70 ILCS 410/4, 410/6, 410/12 and 410/18)

42. Paragraph 2004 of the Tri-County River Valley Development Authority Law. (70 ILCS 525/2004)

43. Paragraph 4b of the Metropolitan Water Reclamation District Act. (70 ILCS 2605/4b)

44. Paragraph 3 and 4 of the Conservation Education Act. (105 ILCS 415/3 and 415/4)

45. Paragraph 22 of the Campground Licensing and Recreational Area Act. (20 ILCS 95/22)

46. Paragraph 12 of the Meat and Poultry Inspection Act. (225 ILCS 650/12)

47. Paragraphs 17 and 1.05 of the Surface-Mined Land Conservation and Reclamation Act. (225 ILCS 715/17 and 720/105)

48. Paragraphs 1 through 16 of the Timber Buyers Licensing Act. (225 ILCS 735/1 et seq.)

49. Paragraphs 1 through 13 of the Forest Products Transportation Act. (225 ILCS 740/1 et seq.)

50. Paragraph 6-15 of the Liquor Control Act of 1934. (235 ILCS 5/6-15)

51. Paragraph 2 of the Pest and Predatory Animal Control Act. (410 ILCS 90/2)

52. Paragraph 3.01 of the Wastewater Land Treatment Site Regulation Act. (415 ILCS 50/3.01)

53. Paragraphs 4 and 19 of the Illinois Pesticide Act. (415 ILCS 60/4 and 60/19)

54. Paragraph 10 of the Litter Control Act. (415 ILCS 105/10)

55. Paragraph 1 through 12 of the Forest Fire Protection District Act. (425 ILCS 40/1 et seq.)

56. Subparagraph 6 and 13 of paragraph 2 of the Firearm Owners

Identification Card Act. (430 ILCS 65/2(6)(13))

57. Paragraph 20.1 of the Agricultural Areas Conservation and Preservation Act. (505 ILCS 5/20.1)

58. Paragraphs 2-1, 2-4, 3-2, 5-1, 5-2, and 5-3 of the Illinois Conservation Enhancement Act. (505 ILCS 35/2-1, 35/2-4, 35/3-2, 35/5-1, 35/5-2, and 35/5-3)

59. Paragraph 3 of the Farmland Preservation Act. (505 ILCS 75/3)

60. Paragraph 1.2 of the Illinois Domestic Animals Running At Large Act. (510 ILCS 55/1.2)

61. Paragraphs 1-1 through 50-1 of the Fish and Aquatic Life Code. (515 ILCS 5/1-1 et seq.)

62. Paragraph 1.1 through 4.4 of the Wildlife Code. (520 ILCS 5/1.1 et seq.)

63. Paragraphs 1 through 11 of the Illinois Endangered Species Protection Act. (520 ILCS 10/1 et seq.)

64. Paragraph 0.01 through 2 of the Wildlife Restoration Cooperation Act. (520 ILCS 15/0.01 et seq.)

65. Paragraphs 0.01 through 22 of the Wildlife Habitat Management Areas Act. (520 ILCS 20/0.01 et seq.)

66. Paragraphs 1 through 49 of the Habitat Endowment Act. (520 ILCS 25/1 et seq.)

67. Paragraphs 1 through 7 of the Cave Protection Act. (525 ILCS 5/1 et seq.)

68. Paragraphs 1 through 5 of the Illinois Exotic Weed Act. (525 ILCS 10/1 et seq.)

69. Paragraphs 1 through 7 of the Illinois Forestry Development Act. (525 ILCS 15/1 et seq.)

70. Paragraphs 1 through 5 of the Ginseng Harvesting Act. (525 ILCS 20/0.01 et seq.)

71. Paragraphs 4 and 5 of the Illinois Lake Management Program Act. (525 ILCS 25/4 and 25/5)

72. Paragraphs 3.07, 3.08, 3.14, 3.15, 5, 6.08, 6.09 7, 7.01, 7.02, 7.03, 7.04, 7.05, 7.06, 13, 16, 24 and 26, of the Illinois Natural Areas Preservation Act. (525 ILCS 30/3.07, 30/3.08, 30/3.14, 30/3.15, 30/5, 30/6.08, 30/6.09, 30/7,30/7.01, 30/7.02, 30/7.03, 30/7.04, 30/7.05, 30/7.06, 30/13, 30/16, 30/24 and 30/26)

73. Paragraphs 1 through 14 of the Open Space Lands Acquisition and Development Act. (525 ILCS 35/1 et seq/)

74. Paragraphs 0.01 through 9 of the State Forest Act. (525 ILCS 40/0.01 et seq.)

75. Paragraphs 1 through 8 of the Illinois Youth and Young Adult Employment Act of 1986. (525 ILCS 50/1 et seq.)

76. Paragraphs 2-2220, 4-201.5 and 4-201.15 of the Illinois Highway Code. (605 ILCS 5/4-220, 5/4-201.5 and 5/4-201.15)

77. Paragraph 4 of the Bikeways Act. (605 ILCS 30/4)

78. Paragraph 0.01 through 30 of the Illinois And Michigan Canal Management Act. (615 ILCS 30/0.01 et seq.)

79. Paragraphs 0.01 through 30 of the Illinois And Michigan Canal Management Act. (615 ILCS 30/0.01 et seq.)

80. Paragraphs 0.01 through 7 of the Illinois And Michigan Canal Protection Act. (615 ILCS 35/0.01 et seq.)

81. Paragraphs 0.01 through 2 of the Illinois and Michigan Canal Land Use Act. (615 ILCS 40/0.01 et seq.)

82. Paragraphs 0.01 through 14 of the Illinois and Michigan Canal Development Act. (615 ILCS 45/0.01 et seq.)

83. Paragraphs 0.01 through 1 of the Lincoln Reservoir Act. (615 ILCS 70/0.01 et seq.)

84. Paragraphs 3 and 4 of the Vermilion River Middle Fork Act. (615 ILCS 95/3 and 95/4)

85. Paragraphs 0.01 through 4 of the McHenry County Dam Act. (615 ILCS 100/0.01 et seq.)

86. Paragraphs 0.01 through 5 of the Illinois and Mississippi Canal State Park Act. (615 ILCS 105/0.01 et seq.)

87. Sub-paragraph 5 of paragraph 11-1426 of the Illinois Vehicle Code. (625 ILCS 5/11-1426(5))

88. Paragraphs 1-1 through 11-1 of the Snowmobile Registration and Safety Act. (625 ILCS 40/1-1 et seq.)

89. Paragraphs 1-1 through 13-1 of the Boat Registration and Safety Act. (625 ILCS 45/1-1 et seq.)

90. Paragraph 5 of the Premises Liability Act. (740 ILCS 130/5)

91. Paragraphs 0.01 through 7 of the Wrongful Tree Cutting Act. (740 ILCS 185/0.01 et seq.)

92. Paragraph 2.13 of the Good Samaritan Food Donor Act. (745 ILCS 50/2.13)

93. Paragraph 5 of the Real Property Conservation Rights Act. (765 ILCS 12 0/5)

B. FROM THE DEPARTMENT OF ENERGY AND NATURAL RESOURCES TO THE DEPARTMENT OF NATURAL RESOURCES

The following rights, powers and duties by law vested in the Department of Energy and Natural Resources, or any office, division or bureau thereof by the following Acts or sections thereof, and all rights, powers, and duties incidental thereto, are transferred to the Department of Natural Resource:

1. Section 1 of the State Museum Construction Act (15 ILCS 315/1)

2. Sections 3, 4 and 6.08 of the Civil Administrative Code of Illinois (Part 1) (20 ILCS 5/3, 4 and 6.08

3. Sections 4(c)(8) and 4c(c)(11) of the Personnel Code (20 ILCS 415/4(c)(8) and4(c)(11))

4. Section 15(k) of the Business Assistance and Regulatory Reform Act 920 ILCS 608/15(k))

5. Section 2003(c) of the Technology Advancement and Development Act (20 ILCS 700/2003(c))

6. Section 2-1 of the Interagency Wetlands Policy Act of 1989 (20 ILCS 830/2-1)

7. Sections 1 and 2 of the Natural Resources Act (20 ILCS 1105/1 and 2)

8. Sections 1 and 2 of the Natural Resources Act (20 ILCS 1105/3(a)(5) and(6))

9. Section 3(a)(12) of the Natural Resources Act (20 ILCS 1105/3(a)(12))

10. Sections 3(b)(1) to (24) of the Natural Resources Act (20 ILCS 1105/3(b)(1)-(24))

11. Sections 3(b)(26) of the Natural Resources Act (20 ILCS1105/3(b)(26))

12. Sections 3(c) of the Natural Resources Act (20 ILCS 1105/3(c))

13. Section 3(f) of the Natural Resources Act (20 ILCS 1105/3(f))

14. Sections 6 and 7 of the Natural Resources Act (BNRC) (20 ILCS 1105/6 and 7)

15. Section 13.1 of the Natural Resources Act (20 ILCS 1105/13.1)

16. Section 16 of the Natural Resources Act (20 ILCS 1105/16)

17. Energy Policy and Planning Act (20 ILCS 1120/1 et seq.)

18. Dickson Mounds State Memorial Act (20 ILCS 1125/0.01 et seq.)

19. Hazardous Waste Technology Exchange Service Act (20 ILCS 1130/1 et seq.)

20. Superconducting Super Collider Act (20 ILCS 1135/1 et seq.)

21. Section 1.04(f) of the Abandoned Mined Lands and Water Reclamation Act (20 ILCS 1920/1.04(f))

22. Section 71(I) of the Civil Administrative Code of Illinois (Part 16.5) (20 ILCS 2005/71(I))

23. Section 49.06(f) of the Civil Administrative Code Illinois (Part8.5) (20 ILCS 2705/49.06(f))

24. Section 14(d) of the Capital Development Board Act (20 ILCS 3105/14(d))

25. Section 6 of the Historic Preservation Agency Act (20 ILCS 3405/6

26. Section 3 of the Historic Preservation Act (20 ILCS 3410/3)

27. Sections 7, 8(a) and 10 of the Archeological and Paleontological Resources Protection Act (20 ILCS 3435/7, 8(a) and 10)

28. Sections 13(a) and 14 of the Human Skeletal Remains Protection Act (20 ILCS 3440/13(a) and 14)

29. Section 1 of the Science Advisory Council Act (20 ILCS 4025/1)

30. Sections 5.88, 5.121, 5.225, 6z14 and 8.24 of the State Finance Act (30ILCS 105/5.88, 5.121, 5.225, 6z14 and 8.24)

31. Section 1 of the Environmental Protection Trust Fund Act (30 ILCS 125/1)

32. Section 2-1 of the Building Illinois Act (30 ILCS 750/2-1)

33. Illinois Hazardous and Solid Waste Recycling and Trustment Act (30 ILCS 750/3-1 et seq.)

34. Section 15-106 of the Illinois Pension Code (40 ILCS 5/15-106)

35. Section 12-19 of the Illinois Drainage Code (70 ILCS 605/12-19)

36. Section 13 of the Mosquito Abatement District Act (70 ILCS 1005/13)

37. Section 24 of the Solid Waste Disposal District Act (70 ILCS 3105/24)

38. Section 6.8 of the Water Authorities Act (70 ILCS 3715/6.8)

39. Section 62 of the Civil Administrative Code of Illinois (Part 13) (110 ILCS 355/62)

40. Section 1 of the Forestry Promotion Act (110 ILCS 360/1)

41. Section 143.21(c) of the Illinois Insurance Code (215 ILCS 5/143.21(c))

42. Sections 8-401, 8-402 and 8-405.1 of the Public Utilities Act (220 ILCS 5/8-410, 8-402 and 8-405.1)

43. Sections 1.03(a)(8), 7.03 and 7.04 of the Surface Coal Mining Land Conservation and Reclamation Act (225 ILCS 720/1.03(a)(8), 7.03 and 7.04)

44. Sections 6(4) of the Illinois Oil & Gas Act (225 ILCS 725/6(4))

45. Well Abandonment Act (225 ILCS 730/1 et seq.)

46. Section 26 of the Illinois Horse Racing Act of 1975 (230 ILCS 5/26)

47. Section 6-15 of the Liquor Control Act of 1934 (235 ILCS 5/6-15)

48. Section 2 of the Pest & Predatory Animal Control Act (410 ILCS 90/2)

49. Section 4(a) of the Illinois Health and Hazardous Substances Registry Act (410 ILCS 525/4(a))

50. Sections 3.07, 5.1(a), 6.2, 11(c), and 13.1 of the Environmental Protection Act (415 ILCS 5/3.07, 5.1(a), 6.2, 11(c), and 13.1)

51. Section 17.1(i) of the Environmental Protection Act (415 ILCS 5/17.1(i))

52. Section 17.2 of the Environmental Protection Act (415 ILCS 5/17.2)

53. Section 17.3 of the Environmental Protection Act (415 ILCS 5/17.3)

54. Sections 22.2(e), 22.2(j)(6)(E)(vi)(II), 22.9, 22.28(g), 27(a), and 55.6(c)(2)(C) of the Environmental Protection Act (415 ILCS 5/22.2(e), 22.2(j)(6)(E)(vi)(II), 22.9 22.28(g), 27(a), 27(a), 55.6(c)(2)(C))

55. Section 6.1 of the Environmental Protection Act (415 ILCS 20/6.1)

56. Sections 3, 4(a)(2), 6, 7, and 8(d) and (e) of the Illinois Groundwater Protection Act (415 ILCS 55/3, 4(a)(2), 6, 7 and 8(d) and (e))

57. Section 19 of the Illinois Pesticide Act (415 ILCS 60/19)

58. Sections 2 to 4 of the Degradable Plastics Act (415 ILCS 80/2 to 4)

59. Section 3, 4(5) and 7 of the Toxic Pollution Prevention Act Act (415 ILCS 85/3, 4(5) and 7)

60. Section 10 of the Illinois Pollution Prevention Act (415 ILCS 115/10)

61. Section 10 and 10.2 of the Illinois Low-Level Radioactive Waste Management Act (420 ILCS 20/10 and 10.2)

62. Section 20.1 of the Agriculture Areas Conservation and Pollution Act (505 ILCs 5/20.1)

63. Section 3 of the Farmland Preservation Act (505 ILCS 75/3)

64. Section 1.3 of the Wildlife Code (520 ILCS 5/1.3)

65. Sections 4 and 5 of the Illinois Natural Areas Preservation Act (525 ILCS 30/4 and 30/5)

66. Section 5 of the Water Use Act of 1983 (525 ILCS 45/5)

67. Section 14(a) of the Rivers, Lakes and Streams Act (615 ILCS 5/14(a)

68. Section 5/7-103 of the Code of Civil Procedure (735 ILCS 5/7-103)

C. FROM THE DEPARTMENT OF MINES AND MINERALS TO THE DEPARTMENT FO NATURAL RESOURCES

The following rights, powers and duties by law vested in the Department of Mines and Minerals, or any office, division or bureau thereof by the following Acts or sections thereof, and all rights, powers, and duties incidental thereto, are transferred to the Department fo Natural Resources:

1. The Oil and Gas Wells on Public Lands Act (5 ILCS 615/0.01 et seq.)

2. Sections 3, 4, 5.04 7.02 and 9.04 of the Civil Administrative Code Illinois (20 ILCS 5/3, 5/4, 5/5.04, 5/7.02 and 5/9.04)

3. Section 40.38 of Part 4 of the Civil Administrative Code of Illinois (20 ILCS 205/40.38)

4. Section 2-1 of the Interagency Wetland Policy Act of 1989 (20 ILCS 830/2-1)

5. Section 8 of "An Act in relation to natural resources, research, data collection and environmental studies", approved and effective July 14, 1978 (20 ILCS 1105/8)

6. Sections 45.1, 45.2 and 46 of Part 6.5 of the Civil Administrative Code of Illinois (20 ILCS 1905/45, 1905/45.1 1905/45.2 and 1905/46)

7. Coal Products Commission Transfer Act (20 ILCS 1910/0.01 et seq.)

8. Surface Coal Mining Fee Act (20 ILCS 1915/0.01 et seq.)

9. Section 1.04 of the Abandoned Minded Lands and Water Reclamation Act (20 ILCS 1920/1.04)

10. SEctions 6z-36 and 6z37 of the State Finance Act (30 ILCS 105/6z-15, 105/6z-36 and 105/6z-37)

11. Section 4 of the Illinois Mined Coal Act (30 ILCS 555/4)

12. Sections 2 and 3 of the Interstate Mining Compact Act (45 ILCS 50/2 and 50/3)

13. Illinois Explosives Act (225 ILCS 210/1001 et seq.)

14. Coal Mining Act (225 ILCS 705/1.01 et seq.)

15. Fluorspar and Underground Limestone Mines Act (225 ILCS 710/1 et seq.)

16. Surface-Mined Land Conservation and Reclamation Act (225 ILCS 715/1 et seq.)

17. Surface Coal Mining Land Conservation and Reclamation Act (225 ILCS 720/1.01 et seq.)

18. Illinois Oil and Gas Act (225 ILCS 725/1 et seq.)

19. Well Abandoned Act (225 ILCS 730/1 et seq.)

20. Coal Mine Medical Emergencies Act (410 ILCS 15/1 et seq.)

21. Sections 18 and 45 of the Environmental Protection Act (415 ILCS 5/18, 5/45)

22. Sections 4 and 9 of the Illinois Groundwater Protection Act (415 ILCS 55/4, 55/9)

23. Section 4 of the Hazardous Materials Emergency Act (430 ILCS 50/4)

24. Section 5 of the Boiler and Pressure Vessel Safety Act (430 ILCS 75/5)

25. Section 20.1 of the Agricultural Areas Conservation and Protection Act (505 ILCS 5/20.1)

26. Section 3 of the Farmland Preservation Act (505 ILCS 75/3)

27. Section 221c of "An Act to revise the law in relation to criminal jurisprudence", approved March 27, 1874 and effective July, 1874 (740 ILCS55/221c)

28. Section 1 of the Oil and Gas Recovery Act (765 ILCS 525/1)

29. Drilling Operations Act (765 ILCS 530/1 et seq.)

30. Sections 1 and 3 of the Oil and Gas Lien Act 1989 (770 ILCS 70/1, 70/3)

D. FROM THE ABANDONED MINED LANDS RECLAMATION COUNCIL TO THE DEPARTMENT OF NATURAL RESOURCES

The following rights, powers and duties by law vested in the Abandoned Mined Lands Reclamation Council, or any office, division or bureau thereof by the following Acts or sections thereof, and all rights, powers, and duties incidental thereto, are transferred to the Department of Natural Resources:

1. The Abandoned Minded Lands and Water Reclamation Act (20 ILCS 1920 et seq.)

2. Section 6a-1-a of the Illinois Purchasing Act (30 ILCS 505/6a-1-a)

3. Section 21(r)(2) of the Environmental Protection Act (415 ILCS 5/21(r)(2))

4. Section 2 of the Surface Coal Mining Fee Act (20 ILCS 1915/2)

5. Section 1-3 of the Building Act (30 ILCS 750/1-3)

6. Section 6735 of the Civil Administrative Code (20 ILCS 405/67.35)

E. FROM THE DIVISION OF WATER RESOURCES OF THE DEPARTMENT OF TRANSPORTATION TO THE DEPARTMENT OF NATURAL RESOURCES

The following rights, power and duties by law vested in the Division of Water Resources of the Department of Transportation, or any office, division or bureau thereof by the following Acts or sections thereof, and all rights powers, and duties incidental thereto, are transferred to the Department of Natural Resources:

1. The Abandoned Mined Lands and Water Reclamation Act (20 ILCS 1920 et seq.)

2. Section 6a-1-a of the Illinois Purchasing Act (30 ILCS 505/6a-1-a)

3. Section 21(r)(2) of the Environmental Protection Act (415 ILCS 5/21(r)(2))

4. Section 2 of the Surface Coal Mining Fee Act (20 ILCS 1915/2)

5. Section 1-3 of the Building Illinois Act (30 ILCS 750/1-3)

6. Section 67.35 of the Civil Administrative Code (20 ILCS 405/67.35)

E. FROM THE DIVISION OF WATER RESOURCES OF THE DEPARTMENT OF TRANSPORTATION TO

THE DEPARTMENT OF NATURAL RESOURCES

The following rights, powers and duties by law vested in the Division of Water Resources of the Department to Transportation, or any office, division or bureau thereof by the following Acts or sections thereof, and all rights, powers, and duties incidental thereto, are transferred to the Department of Natural Resources:

1. Section 51 of the Civil Administrative Code of Illinois (Part 9) (20 ILCS 5/51) replace Department of conservation with Department of Natural Resources

2. Sections 49.04, 49.05, 49.06a, 49.06c, 49.06d, 49.06e, 49.06f, 49.12 and 49.13 of the Civil Administrative Code of Illinois (Part 8.5) (20 ILCS 2705/49.04, 49.05, 49.06a, 49.06c, 49.06d, 49.06e, 49.06f, 49.12 and 49.13) Natural Resources to sections 49.12 and 49.13

3. Section 3 of the Capital Development Board Act (20 ILCS 3105/3) add Department of Natural Resources

4. Section 5 of the Illinois Emergency Management Agency Act (20 ILCS 3305/5)

5. Section 3h of the Capital Development Bond Act (30 ILCS 420/3(h))

6. Build Illinois Bond Act (30 ILCS 425)

7. Sections 3-5029, 5-1062(d), 5-1062(f), 5-1062.1, 5-15013 and 5-40001 of the Counties Code (55 ILCS 5/3-5029, 5-1062(d), 5-1062(f), 5-1062.1, 5-15013 and 5-40001)

8. Section 11-92-2 of the Illinois Municipal Code (65 ILCS 5/11-92-2)

9. Section 12-19 of the Illinois Drainage Code (70 ILCS 605/12-19)

10. Sections 11.1-2 and 11.1-4 of the Park District Code (70 ILCS 1205/11.1-2 and 11.1-4)

11. Section 26.2 of the Chicago Park District Act (70 ILCS 1505/26.2)

12. Section 37 of the Havana Regional Port District Act (70 ILCS 1805/37)

13. Sections 4a and 26 of the Illinois International Port District Act (70 ILCS 1810/4a)

14. Section 48 of the Illinois Valley Regional Port District Act (70 ILCS 1815/48)

15. Section 29 of the Illinois Counties Regional Port District Act (70 ILCS 1820/29)

16. Section 29 of the Joliet Regional Port District Act (70 ILCS 1825/29)

17. Section 49 of the Kaskaskia Regional Port District Act (70 ILCS 1830/49)

18. Section 34 of the Mt. Carmel Regional Port District Act (70 ILCS 1835/34)

19. Section 30 of the Seneca Regional Port District Act (70 ILCS 1845/30)

20. Section 30 of the Shawneetown Regional Port District Act (70 ILCS 1850/30)

21. Section 34 of the Southwest Regional Port District Act (70 ILCS 1855/34)

22. Section 30 of the Tri-City Regional Port District Act (70 ILCS 1860/30)

23. Section 30 of the Waukegan Port District Act (70 ILCS 1860/30)

24. Section 4c and 27 of the White County Port District Act (70 ILCS 1870/4c and 37)

25. Section 2 of the Rend Lake Dam and Reservoir Act (70 ILCS 2115)

26. Section 7 of the North Shore Sanitary District Act (70 ILCS 2305/7)

27. Section 5.2, 8 and 55 of the Metropolitan Water Reclamation District Act (70 ILCS 2605/5.2, 8, and 55)

28. Section 4-2(3) of the Metro-East Sanitary District Act of 1974 (70 ILCS 2905/4-2(3)

29. Section 17 of the Surface-Mined Land Conservation and Reclamation Act (225 ILCS 715/17)

30. Section 1.05 of the Surface Coal Mining Land Conservation and Reclamation Act (225 ILCS 720/105)

31. Section 4(6) of the Illinois Groundwater Protection Act (415 ILCS 55/4(6))

32. Sections 4a and 5 of the Illinois Lake Management Program Act (525 ILCS 25/4a and 5)

33. Section 5 through 30 of the Rivers, Lakes and Streams Act (615 ILCS 5-30)

34. Sections 6 through 18 of the Illinois Waterway Act (615 ILCS 10/6 -18)

35. Sections 1 through 9 of the Flood Control Act of 1945 (615 ILCS 15/1-9)

36. Sections 1 through 5 of the Navigable Waters Obstruction Act (615 ILCS 20/1-5)

37. Sections 1 through 14 of the Level of Lake Michigan Act (615 ILCS 50/1-14)

38. Sections .01 through 6 of the Lake Michigan Shore Line Act (615 ILCS 55/01-6)

39. Sections 2 and 3 of the Des Planes and Illinois Rivers Act (615 ILCS 60/2 and 3)

40. Section 5 of the Lake Calumet Harbor Act (615 ILCS 65/5)

41. The Kaskaskia River Watershed and Basin Act (615 ILCS 75)

42. Section 1 of the Big Kincaid Creed Reservoir Act (615 ILCS 80/1)

43. The Blue Waters Ditch Flood Control Act (615 ILCS 85)

44. Sections 1 through 4 of the McHenry County Dam Act (615 ILCS 100/1-4)

45. The Illinois and Mississippi Canal Park Act (615 ILCS 105) replace every management of Department of Transportation with Department of Natural Resources in all sections 1 through 5)

46. Section 10-1 of the State Boating Act Fund (625 ILCS 45/10-1) replace Department of Transportation with Department of Natural Resources)

F. FROM THE DEPARTMENT OF CONSERVATION TO THE HISTORIC PRESERVATION AGENCY

The following rights, powers and duties by law vested in the Department fo Conservation, or any office, division or bureau thereof by the following Acts or sections thereof, and all rights, powers, and duties incidental thereto, are transferred to the Historic Preservation Agency:

1. Paragraphs 0.01 through 3 of the Lincoln Monument Act. (20 ILCS 8150.01 et seq.)

G. FROM THE DEPARTMENT OF ENERGY AND NATURAL RESOURCES TO THE DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

The following rights, powers and duties bylaw vested in the Department fo Energy and Natural Resources, or any office, division or bureau thereof by the following Acts or sections thereof, and all rights, powers, and duties incidental thereto, are transferred to the Department of Commerce and Community Affairs:

1. Section 67.30 of the Civil Administrative Code Illinois (Part 15) (20 ILCS 405/67,30)

2. Sections 46.3 and 46.19b of the Civil Administrative Code Illinois (Part 7) (20 ILCS 605/46.3 and 46.19b)

3. Sections 3(a)(1) to (a)(4) of the Natural Resources Act (20 ILCS

1105/3(a)(1) to (a)(4))

4. Sections 3(a)(7) to 3(a)(11) of the Natural Resources Act (20 ILCS 1105/3(a)(7) to (a)(11)

5. Section 3(b)(25) of the Natural Resources Act (20 ILCS 1105/3(b)(25))

6. Section 3(h) of the Natural Resources Act (20 ILCS 1105/3(h))

7. Section 8 of the Natural Resources Act (20 ILCS 1105/8)

8. Section 9 through 13 of the Natural Resources Act (20 ILCS 1105/9, 10, 11, 12 and 13)

9. Sections 14 and 15 of the Natural Resources Act (20 ILCS 1105/14 and 15)

10. Illinois Coal and Energy Development Bond Act (20 ILCS 1110/1 et seq.)

11. Energy Conservation Act (20 ILCS 1115/1 et seq.)

12. Section 10.4 of the Capital Development Board Act (20 ILCS 3105/10.4)

13. Sections 7051(d) and 7.53(p) of the Illinois Development Finance Authority Act (20 ILCS 3505/7.51(d) and 7.53(p)

14. Section 4.23 of the Illinois Health Facilities Authority Act (20 ILCS 3705/4.23)

15. Sections 10 and 15 of the Government Buildings Energy Cost Reduction Act of 1991 (20 ILCS 3953/10 and 15)

16. Section 11A-6(g) of the Legislative Commission Reorganization of 1984 (Article 11A) (25 ILCS 130/11A-6(g))

17. Exxon Overchange Fund Act (30 ILCS 130/3)

18. Section 7 of the General Obligation Bond Act (30 ILCS 330/7)

19. Section 9.06 of the Illinois Purchasing Act (30 ILCS 505/9.06)

20. Rural Energy Development Act (30 ILCS 7102-1 et seq)

21. Comprehensive Solar Energy Act of 1977 (30 ILCS725/1 et seq.)

22. Illinois Coal Technology Development Assistance Act (30 ILCS 730/1 et seq.)

23. Section 6.1 of the Environmental Protection Act (415 ILCS 5/6.1)

24. Section 1.1(b) of the Hot Water Heater Efficiency Act (815 ILCS 355/1.1(b))

H. FROM THE DEPARTMENT OF ENERGY AND NATURAL RESOURCES TO THE ENVIRONMENTAL PROTECTION AGENCY

The following rights, powers and duties by law vested in the Department of Energy and Natural Resources, or any office, division or bureau thereof by the following Acts or sections thereof, and all rights, powers, and duties incidental thereto are transferred to the Environmental Protection Agency:

1. Section 3(d) and (e) of the Natural Resources Act (20 ILCS 1105/3(d) and (e))

2. Section 3(g) of the Natural Resources Act (20 ILCS 1105/3(g))

3. Used Motor Oil Recycling Act (20 ILCS 1140/1001 et seq.)

4. Section 34-18.15(f) of the School Code (105 ILCS 5/34-18.15(f))

5. Sections 21.6(d), 22.15(a), 22.15(e), 22.15(g), 22.16b(a)(1), 22.23(g) and 22.23(I) of the Environmental Protection Act (415 ILCS 5/21.6(d), 22.15(a), 22.15(e), 22.15(g), 22.16b(a)(1), 22.23(g), and 22.23(I))

6. Sections 21.6(d), 22.15(a), 22.15(e), 22.15(g), 22.16b(a)(1), 22.23(g) and 22.23(I) of the Environmental Protection Act (415 ILCS 5/22.27, 55(b)(2), 55.3(f), 55.6(c)(2)(A), (B), (D) and (E), 55.6(f) and (g)(2) and 55.7)

7. Sections 3, 7(c), 8 and 8.5 of the Solid Waste Planning and Recycling Act [415 ILCS 15/3, 7(c), 8 and 8.5)

8. Sections 2.1, 3(b)(c)(i)(L), 3.1(f) and (g), 5, 6, and 6a of the Illinois Solid Waste Management Act [415 ILCS 20/2.1, 3(b)(c)(i)(L), 3.1(f) and (g), 5, 6 and 6a)

9. Section 6.2 of the Illinois Solid Waste Management Act [415 ILCS 20/6.2]

10. Sections 6.3, 7, 7.3 and 8 of the Illinois Solid Waste Management Act [415 ILCS 20/6.3, 7, 7.3, and 8]

11. Sections 2002.50, 2004, 2005, 2007 to 2013 of the Recycled Newsprint Use Act [415 ILCS 110/2002.50, 2004, 2005, and 2007 to 2013]

12. Waste Oil Recovery Act [815 ILCS 440/1 et seq.]

III. EFFECT OF TRANSFER

A. The Department of Energy and Natural Resources, the Department of Mines and Minerals, the Abandoned Mined Lands Reclamation Council and the Division of Water Resources of the Department of Transportation and all offices, bureaus and divisions of each are hereby abolished. The Department of Conservation is hereby redesignated as the Department of Natural Resources.

B. The following offices are abolished: the Director of the Department of Energy and Natural Resources, the Director of Mines and Minerals and the Assistant Directors of Mines and Minerals.

C. Personnel previously assigned to the Department of Energy and Natural Resources, the Department of Mines and Minerals, the Abandoned Mined Lands Reclamation Council and the Division of Water Resources of the Department of Transportation are transferred to the Department of Natural Resources. Personnel exercising rights, powers and duties in the Department of Conservation that are retained within the Department of Natural Resources shall continue their service within the renamed Department.

Personnel exercising rights, powers and duties in the Department of Energy and Natural Resources that are transferred by this Executive Order to the Environmental Protection Agency.

Personnel exercising rights, powers and duties in the Department of Energy and Natural Resources that are transferred by this Executive Order to the Department of Commerce and Community Affairs are transferred to the Department of Commerce and Community Affairs.

The rights of the employees, the State and its agencies under the Personnel Code or any collective bargaining agreement, or under any pension, retirement or annuity plan, shall not be affected by this Executive Order.

D. All books, records, papers, documents, property (real and personal), and unexpended appropriations and pending business in any way pertaining to the rights, powers and duties transferred by this Executive Order from the Department of Energy and Natural Resources, the Department of Mines and Minerals, the Abandoned Mined Lands Reclamation Council and the Division of Water Resources of the Department of Transportation to the Department of Natural Resources shall be delivered and transferred to the Department of Natural Resources. All books, records, papers, documents, property (real and personal), and unexpended appropriations and pending business in any way pertaining to the rights, powers and duties retained from the Department of Conservation by the Department of Natural Resources shall be retained by the Department of Natural Resources.

All books, records, papers, documents, property (real and personal), and unexpended appropriations and pending business in any way pertaining to the rights, powers and duties transferred by this Executive Order from the Department of Energy and Natural Resources to the Environmental Protection Agency shall be delivered and transferred to the Environmental Protection Agency.

All books, records, papers, documents, property (real and personal), and unexpended appropriations and pending business in any way pertaining to the rights, powers and duties transferred by this Executive Order from the

Department of Energy and Natural Resources to the Department of Commerce and Community Affairs shall be delivered and transferred to the Department of Commerce and Community Affairs.

All books, records, papers, documents, property (real and personal), and unexpended appropriations and pending business in any way pertaining to the rights, powers and duties transferred by this Executive Order from the Department of Conservation to the Historic Preservation Agency shall be delivered and transferred to the Historic Preservation Agency.

IV. SAVINGS CLAUSE

A. The rights, powers and duties transferred or retained by this Executive Order to the Department of Natural Resources, the Department of Commerce and Community Affairs, the Environmental Protection Agency and the Historic Preservation Agency shall be vested in and shall be exercised by these Departments or Agencies subject to the provisions of this Order. Each act done in the exercise of such rights, powers and duties shall have the same legal effect as if done by the former departments, agencies, divisions, officers or employees thereof.

B. Every person or corporation shall be subject to the same obligations and duties and any penalties, civil or criminal, arising therefrom, and shall have the same rights arising from the exercise of such rights, powers and duties as if such rights, powers and duties had been exercised by the former departments, agencies, divisions, officers or employees thereof.

C. Every officer and employee of the Department of Natural Resources, the Environmental Protection Agency the Department of Commerce and Community Affairs or the Historic Preservation Agency shall, for any offense, be subject to the same penalty or penalties, civil or criminal, as are prescribed by existing law for the same offense by any officer or employee whose powers or duties were transferred to him or retained by him by this Executive Order.

D. Whenever reports or notices are now required to be made or given or papers or documents furnished or served by any person to or upon the departments and offices transferred by this Executive Order, the same shall be made, given, furnished or served in the same manner to or upon the successor department or agency.

E. This Executive Order shall not affect any act done, ratified or cancelled or any right occurring or established or any action or proceeding had or commenced in an administrative, civil or criminal cause before this Executive Order takes effect, but such actions or proceedings may be prosecuted and continued by the Department of Natural Resources, the Environmental Protection Agency, the Department of Commerce and Community Affairs of the Historic Preservation Agency, as the case may be.

F. This Executive Order shall not affect the legality of any rules in the

Illinois Administrative Code that are in force on the effective date of this Executive Order that have been duly adopted by the agencies reorganized under this Order. As soon as practicable hereafter, the Department of Natural Resources, the Environmental Protection Agency, the Department of Commerce and Community Affairs and the Historic Preservation Agency shall propose and adopt under the Illinois Administrative Procedure Act such rules as may be necessary to consolidate and clarify the rules of the various reorganized agencies that will now be administered by the successor agency.

V. SEVERABILITY

If any provision of this Executive Order or its application to any person or circumstance is held invalid by any court of competent jurisdiction, this invalidity does not affect any other provision or application of this Executive Order which can be given effect without the invalid provision or application. To achieve this purpose, the provisions of this Executive Order are declared to be severable.

VI. EFFECTIVE DATE

This Executive Order shall become effective on July 1, 1995.

Issued by the Governor March 1, 1995.
Filed by the Secretary of State March 3, 1995.

PROCLAMATIONS

95-083
DR. J. JAYALALITHA DAY

Whereas, the World Federation of Tamil Youth Incorporated is a not-for-profit organization established to channel the energies of youth to constructive purposes and also to instill a sense of pride in our second generation Tamil youth residing in the United States; and

Whereas, the Federation has unanimously resolved to honor Dr. J. Jayalalitha; and

Whereas, Dr. J. Jayalalitha, the first Lady Chief Minister of Tamilnadu, India, will celebrate her 47th birthday on February 24, 1995; and

Whereas, Dr. Jayalalitha has created history by ushering women into a new era of justice and progress; and

Whereas, she is the first Chief Minister in India to initiate a Government Policy for Advancement of Women which is geared towards strengthening equal participation of women in the development of our society and state; and

Whereas, Dr. J. Jayalalitha's initiative, known as the "Vision 2000 Policy", was warmly received at the recent Commonwealth Parliamentary Conference at Alberta, Canada, as a model program; and

Whereas, there are more than one million people of Indian origin in the U.S.;

Thereas, I, Jim Edgar, Governor of the State of Illinois proclaim February 24, 1995, as DR. J. JAYALALITHA DAY in honor of her historic achievements and unparalleled leadership.

Issued by the Governor February 23, 1995.

Filed by the Secretrary of State March 3, 1995.

95-084
POLISH NATIONAL ALLIANCE DAY

Whereas, on February 25, 1995, the Polish National Alliance of the United States observes the 115th anniversary of its founding in Philadelphia and subsequent establishment of its home office in Chicago; and

Whereas, through dedicated and exemplary services, this organization grew from its initial 143 members to the present membership of more than 250,000 with assets of $274 million and presently occupies the position of the largest ethnic fraternal organization in the United States; and

Whereas, among the founding lodges of the Polish National Alliance were societies of the early Polish settlers in Chicago such as Gmina Polska which was founded in 1866, Harmony which was founded in 1879, and other societal units; and

Whereas, through the wide spectrum of its fraternal, civic, socio-cultural, and economic activities, the Polish National Alliance contributed significantly to the growth and development of the State of Illinois and the City of Chicago; and

Whereas, one of its distinguished members, John F. Smolski, was elected State Treasurer in 1906, bringing certain beneficial reforms to that office and, as a financial expert and bank organizer, contributed significantly to the economic development of our state; and

Whereas, through its official publication, the Bi-Monthly Zgoda, founded in 1881 in New York and transferred to Chicago in 1882, and also through its daily publication, the Polish Daily Zgoda, which has been published since 1908, the organization has enhanced the quality of American life with the best values of Polish tradition and culture and throughout decades advocated the concept of ethnicity as a vital ingredient in the immensely rich and diversified culture of pluralism in our society;

Thereas, I, Jim Edgar, Governor of the State of Illinois, proclaim February 25, 1995, as POLISH NATIONAL ALLIANCE DAY in Illinois and ask our citizens to join the members of this organization in the observance of this 115th anniversary.

Issued by the Governor February 23, 1995.

Filed by the Secretrary of State March 3, 1995.

95-085
ROBERT CONRAD DAY

Whereas, on Wednesday March 1, 1995, Robert Conrad will celebrate his 60th birthday; and

Whereas, Mr. Conrad has established himself as one of television's most prolific and enduringly popular stars; and

Whereas, an Illinois native, Bob has returned to Illinois on a regular basis to film a number of projects including "The Duke" in 1979, "Coach of the Year" in 1980, "Will-the Autobiography of G. Gorton Liddy" in 1981, "Hard Knox in 1983, "Two Fathers" in 1984, "Mario and the Mob" in 1991 and "Two Fathers Justice" in 1993, all generating jobs and economic growth in Illinois; and

Whereas, in 1979 he launched his own production company, and has produced many successful motion pictures for television;

Thereas, I, Jim Edgar, Governor of the State of Illinois, proclaim March 1, 1995, as ROBERT CONRAD DAY in Illinois in honor of his successful career and wish him a happy 60th birthday and much continued success.

Issued by the Governor February 24, 1995.

Filed by the Secretrary of State March 3, 1995.

95-086
CHRONIC FATIGUE SYNDROME AWARENESS MONTH

Whereas, Chronic Fatigue Syndrome (CFS) is a debilitating illness which frequently attacks people of all ages. It interrupts education and employment, extracts the enjoyment of life, and causes the accumulation of tremendous medical expenses; and

Whereas, Chronic Fatigue Syndrome is a complex illness characterized by incapacitating fatigue, neurological problems, and other symptoms, often of sufficient severity of qualify patients for Social Security disability; and

Whereas, the National Institutes of Health and the Centers for Disease Control and Prevention are investigating and trying to document the concentration and spread of this syndrome; and

Whereas, the State of Illinois is pleased to join with the Chronic Fatigue Syndrome patients who must struggle to effectively cope with this illness on a daily basis, in celebrating a special month devoted to increasing knowledge and understanding about CFS and in supporting valuable research into its cause and cure;

Thereas, I, Jim Edgar, Governor of the State of Illinois, proclaim March 1995, as CHRONIC FATIGUE SYNDROME AWARENESS MONTH in Illinois.

Issued by the Governor February 28, 1995.

Filed by the Secretrary of State March 3, 1995.

95-087
DUPAGE COUNTY HEALTH DEPARTMENT DAY

Whereas, the DuPage County Health Department has proven exemplary in the important role of guarding the public health of its residents and has come to be known as the award winning health department; and

Whereas, the Environmental Health Division has been named the 1994 recipient of the Crumbine Consumer Award for its food protection program; and

Whereas, this award is given to only one local health department each year and is the highest Consumer Protection Award given in the United States; and

Whereas, the Dental Health Services Unit has been awarded the 1994 Community Health Protection Award from the U.S. Department of Health and Human Services for its Smiling Kids' program; and Whereas, the Nursing Division has received the Cornerstones of Health Award for successful integration of clinics from the Illinois Department of Public Health; and

Whereas, the Nursing Division's Health Moms/Healthy Kids Program has been cited by the Federal Health Care Financing Administration as the model for Healthy Moms/Healthy Kids for the State of Illinois; and

Whereas, the Environmental Health Division has been awarded the Groundwater Protection Award from the Illinois Groundwater Association for leadership in sealing abandoned wells and protecting groundwater; and

Whereas, the Mental Health Division's Disaster Team has been invited to join the National Disaster Medical System (NDMS) as only the fourth disaster team in the specialty of mental health in the nation and the NDMS program reports directly to the Office of the President;

Thereas, I, Jim Edgar, Governor of the State of Illinois, proclaim March 1, 1995, as DUPAGE COUNTY HEALTH DEPARTMENT DAY in Illinois in special recognition of all its outstanding employees and in celebration of 50 years of public health service in DuPage County.

Issued by the Governor February 28, 1995.

Filed by the Secretrary of State March 3, 1995.

95-088
IRISH-AMERICAN HERITAGE MONTH

Whereas, 150 years ago, the blight that struck Ireland's potato crop the single root that changed the history of the world's, known as the Great Famine, caused 2 million of Ireland's population to emigrate, mostly to America's shores; and

Whereas, within a few years of their arrival in the United States, these Irish immigrants took jobs as laborers, built railroads, canals, and schools, dedicated themselves to help build this nation, and this same legacy remains a part of today's American mainstream; and

Whereas, James Smith, George Taylor, Matthew Thornton, and Charles Thomson were four of the individuals signing the Declaration of Independence who were Irish born and nine other signers were of Irish ancestry; and

Whereas, Irish-born James Hoban designed and supervised the building of

the White House and its restoration after it was burned in 1814; and

Whereas, more than 200 Irish-Americans have been awarded the Congressional Medal of Honor; and

Whereas, 19 Presidents of the United States proudly claim Irish heritage, included among them the first president, George Washington; and

Whereas, John W. O'Beirne, founder of the American Foundation for Irish Heritage, first requested in 1990 that Congress designate March as Irish-American Heritage Month; and

Whereas, the 44 million Americans of Irish ancestry, like their forebears, continue to enrich all aspects of life in the United State, in science, education, art, agriculture, business, industry, literature, music, athletics, military, and governmental services;

Thereas, I, Jim Edgar, Governor of the State of Illinois, proclaim March 1995 as IRISH-AMERICAN HERITAGE MONTH in Illinois and urge citizens to observe this month with appropriate ceremonies and activities.

Issued by the Governor February 28, 1995.

Filed by the Secretrary of State March 3, 1995.

95-089
AFRICAN AMERICAN RELIGIOUS CONNECTION CONVENTION DAY

Whereas, the African American Religious Connection Convention will be held March 1-4, 1995, in Chicago; and

Whereas, AARC is an interfaith, interdenominational network consisting of African Americans from all geographical locations, in all disciplines of the religious community; and

Whereas, the not-for-profit organization was founded by Rev. Clay Evans, pastor of Fellowship Missionary Baptist Church in Chicago, president of the Broadcast Ministers Alliance and Chairman Emeritus of Operation PUSH; and

Whereas, one of the AARC's many goals is to develop a communications training program for youth in the areas of radio and television production, gospel video, and audio recordings; and

Whereas, AARC has acquired a radio station in Ohio and is working on a manufacturing company to produce church uniforms, choir robes, and other pastoral clothing wears; and

Whereas, this year's convention will provide a platform to inspire and educate youth to the industries involved in the church through workshops and religious sessions;

Thereas, I, Jim Edgar, Governor of the State of Illinois, proclaim March 1, 1995, as AFRICAN AMERICAN RELIGIOUS CONNECTION CONVENTION DAY in Illinois.

Issued by the Governor March 1, 1995.

Filed by the Secretrary of State March 3, 1995.

95-090
GIRL SCOUT WEEK/GIRL SCOUTS' BE YOUR BEST DAY

Whereas, Girl Scouts of the USA is observing the 83rd anniversary of Girl Scouting, which is a celebration of the vitality of the world's largest voluntary organization for girls; and

Whereas, March 14, 1995, marks the first national Girl Scouts Be Your Best Day, which was initiated by the Girl Scouts of the USA; and

Whereas, for 83 years, Girl Scouting has inspired generations of girls to

improve the world around them in their homes, communities, and their society; and

Whereas, Girl Scouting, open to all girls age five through 17, celebrates its members individuality so that they may develop their full potential, build self-esteem, and develop sound decision-making ability; and

Whereas, it is a celebration of a spirit of adventure that challenges Girl Scouts to learn new skills, to try new activities, and to explore other cultures; and

Whereas, our community has been the direct beneficiary of this 83-year tradition;

Thereas, I, Jim Edgar, Governor of the State of Illinois, proclaim March 12-18, 1995, as GIRL SCOUT WEEK and March 14, 1995, as GIRL SCOUTS' BE YOUR BEST DAY in Illinois and urge the citizens of Illinois to join the nation by pledging to be their individual best.

Issued by the Governor March 1, 1995.

Filed by the Secretrary of State March 3, 1995.

95-091
TREE CITY USA MONTH

Whereas, the forest resources of Illinois help to enhance the quality of life and provide economic well-being by providing benefits of energy conservation, environmental quality, social well-being, wood utilization, and job opportunities; and

Whereas, knowledge of the function and importance of community trees is important to the management of those trees as functional, sustainable ecosystems and important natural resources within the State of Illinois; and

Whereas, each community needs to maintain healthy forest resources for enhanced public safety and well-being; and

Whereas, every citizen should work to provide a natural ecological balance within the environment through responsible stewardship, both individually and collectively; and

Whereas, more than 125 communities have qualified as Tree City USA communities and have made significant contributions toward enhancing the quality of life by improving the forest resources of Illinois; and

Whereas, 41 units of local government have received funds for tree planting through the Small Business Administration Natural Resources Tree Planting Initiative to enhance public land and provide enjoyment; and

Whereas, 33 municipalities received Urban Forestry Assistance Act grants for the establishment and enhancement of existing community forestry efforts;

Thereas, I, Jim Edgar, Governor of the State of Illinois, proclaim April 1995 as TREE CITY USA MONTH in Illinois and ask all citizens to work together to preserve the natural beauty of our state this month and throughout the year.

Issued by the Governor March 1, 1995.

Filed by the Secretrary of State March 3, 1995.

ACTION CODES

A - Adopted Rule	P - Proposed Rule
AR - Adopted Repealer	PF - Prohibited Filing Order by JCAR*
C - Notice of Corrections	PP - Peremptory or Court Ordered Rules
CC - Codification Changes	PR - Proposed Repealer
E - Emergency Rule	R - Refusal to meet JCAR* Objection
ER - Emergency Repealer	RC - Statement of Recommendation
M - Modification to meet JCAR* Objections	S - Suspension ordered by JCAR*
O - JCAR* Statement Of Objections	W - Withdrawal to meet JCAR* Objections
RQ - Request for Correction	MR - Modification and Refusal
EC - Expedited Corrections	

*Joint Committee on Administrative Rules

ALL RULES ARE LISTED BY PART NUMBER AND HEADING ONLY. (FOR ACTION ON SPECIFIC SECTIONS, PLEASE REFER TO THE SECTIONS AFFECTED INDEX.) IF THERE ARE ANY QUESTIONS, PLEASE CONTACT THE ADMINISTRATIVE CODE DIVISION AT (217) 782-7017.

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89 Ill. Adm. Code 240 Community Care Program (P-1363)

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8 Ill. Adm. Code 255 Agrichemical Facilities (P-1)
8 Ill. Adm. Code 60 Bees And Apiary Act (P-754)
8 Ill. Adm. Code 256 Lawncare Wash Water And Rinsate Collection (P-13)
8 Ill. Adm. Code 125 Meat And Poultry Inspection Act (PP-1342)
8 Ill. Adm. Code 600 Weights And Measures Act (P-2356)

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77 Ill. Adm. Code 2090 Subacute Alcoholism And Substance Abuse Treatment Services (P-1156) (P-3106)

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44 Ill. Adm. Code 950 Bidder Responsibility, Prequalification And Suspension Of Contractors (P-2074) (PR-2087)

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44 Ill. Adm. Code 5000 Acquisition, Management & Disposal Of Real Property (P-5057/94;A-585)
80 Ill. Adm. Code 303 Conditions Of Employment (P-2524)
80 Ill. Adm. Code 302 Merit And Fitness (P-2539)
80 Ill. Adm. Code 310 Pay Plan (P-764) (P-14256/94;A-1024) (P-2365) (PP-2481) (PP-3073) (P-3122)

(P-16490 94;A-3456)
80 Ill. Adm. Code 2110 State Of Illinois Dependent Care Assistance Plan (P-774)
80 Ill. Adm. Code 2120 State Of Illinois Medical Care Assistance Plan (P-779)
80 Ill. Adm. Code 3000 The Travel Regulation Council (P-2093)
80 Ill. Adm. Code 2800 Travel (P-12567/94;A-36) (P-2098)

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89 Ill. Adm. Code 336 Appeal Of Child Abuse And Neglect Investigation Findings (P-11407/94;A-3465)
89 Ill. Adm. Code 434 Audits, Reviews, And Investigations (P-8777/94;A-2760)
89 Ill. Adm. Code 428 Department Advisory Council, Illinois Juvenile Justice Commission And Other Statewide And Regional Committees (P-561/94;A-1043)
89 Ill. Adm. Code 406 Licensing Standards For Day Care Homes (P-2683/94;RC-2314) (P-2683/94;A-2765)
89 Ill. Adm. Code 402 Licensing Standards For Foster Family Homes (P-8237/94;A-1801)
89 Ill. Adm. Code 408 Licensing Standards For Group Day Care Homes (P-2700/94;RC-2315) (P-2700/94;A-2784)
89 Ill. Adm. Code 300 Reports Of Child Abuse & Neglect (P-8240/94;A-3469)
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14 Ill. Adm. Code 550 Local Tourism And Convention Bureau Program (P-14189/94;A-1808)

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92 Ill. Adm. Code 1205 Fees And Taxes (P-525)
92 Ill. Adm. Code 1536 Grade Crossing Closure & Opening (P-2550)
83 Ill. Adm. Code 410 Standards Of Service For Electric Utilities (P-14521/94;A-2804)

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23 Ill. Adm. Code 1501 Administration Of The Illinois Public Community College Act (P-12575/94;A-2299) (P-13562/94;A-2816)

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80 Ill. Adm. Code 100 Merit Commission Rules (P-12585/94;A-206)

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17 Ill. Adm. Code 110 Public Use Of State Parks & Other Properties Of The Department Of Conservation (P-1387)
17 Ill. Adm. Code 810 Sport Fishing Regulations For The Waters Of Illinois (P-17297/94;A-2396)
17 Ill. Adm. Code 710 The Taking Of Wild Turkeys-Spring Season (P-16500/94;A-2450)
17 Ill. Adm. Code 670 White-Tailed Deer Hunting By Use Of Bow And Arrow (P-1393)
17 Ill. Adm. Code 650 White-Tailed Deer Hunting By Use Of Firearms (P-1414)
17 Ill. Adm. Code 660 White-Tailed Deer Hunting Season By Use Of Muzzleloading Rifles (P-1437)

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35 Ill. Adm. Code 372 Illinois Design Standards For Slow Rate Land Application Of Treated Wastewater (P-4524;94;A-1297)
35 Ill. Adm. Code 870 Procedures For Issuing Solid Waste Planning And Enforcement Grants (P-2144)

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38 Ill. Adm. Code 160 Sales Finance Agency Act (P-14276/94;A-49)

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50 Ill. Adm. Code 601 Foreign And Alien Insurer Annual Audited Financial Reports (PR-2376)
50 Ill. Adm. Code 2018 Long-Term Care Partnership Insurance (P-2203)
50 Ill. Adm. Code 3401 Summary Document, Disclaimer & Notice (P-784)
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47 Ill. Adm. Code 610 Illinois Americorps Program (P-15691/94;A-3494)

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62 Ill. Adm. Code 1840 Department Inspections (P-1485)
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62 Ill. Adm. Code 1701 General Definitions (P-1498) (C-2319)
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62 Ill. Adm. Code 1773 Requirements For Permits And Permit Processing (P-1637)
62 Ill. Adm. Code 1785 Requirements For Permits For Special Categories Of Mining (P-1653)
62 Ill. Adm. Code 1774 Revision; Renewal; And Transfer, Assignment, Or Sale Of Permit Rights (P-1663)
62 Ill. Adm. Code 1795 Small Operator Assistance (P-1670)
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62 Ill. Adm. Code 1780 Surface Mining Permit Application--Minimum Requirements For Reclamation And Operation Plan (P-1687)
62 Ill. Adm. Code 1779 Surface Mining Permit Applications - Minimum Requirements For Information On Environmental Resources (P-1692)
62 Ill. Adm. Code 140 The Coal Mining Act (P-16054/94;A-2461)
62 Ill. Adm. Code 240 The Illinois Oil And Gas Act (P-2215)
62 Ill. Adm. Code 1850 Training, Examination And Certification Of Blasters (P-1697)
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68 Ill. Adm. Code 1150 Illinois Architecture Practice Act Of 1989 (P-1180)
68 Ill. Adm. Code 1200 Illinois Certified Shorthand Reporters Act Of 1984 (P-12103/94;A-940)
68 Ill. Adm. Code 1270 Illinois Professional Land Surveyor Act Of 1989 (P-1185)
68 Ill. Adm. Code 1255 Interior Design Profession Title Act (P-2646)

68 Ill. Adm. Code 1240 Private Detective, Private Alarm And Private Security Act Of 1993 (P-14567/94;A-954)
68 Ill. Adm. Code 1300 The Illinois Nursing Act Of 1987 (P-2658)
68 Ill. Adm. Code 1380 The Professional Engineering Practice Act Of 1989 (P-1190)
68 Ill. Adm. Code 1480 The Structural Engineering Licensing Act Of 1989 (P-1195) (P-16901/93;A-2309)

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89 Ill. Adm. Code 113 Aid To The Aged, Blind Or Disabled (P-815) (P-14281/94;A-1052) (P-14590/94;A-2875)
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89 Ill. Adm. Code 147 Reimbursement For Nursing Costs For Geriatric Facilities (P-1730)
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77 Ill. Adm. Code 845 Lead Poisoning Prevention Code (P-8021/94;A-238)
77 Ill. Adm. Code 615 Local Health Protection Grant Rules (P-833)
77 Ill. Adm. Code 905 Private Sewage Disposal Code (P-22359/93;O-18405/94;W-287) (P-3299)
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77 Ill. Adm. Code 790 The Illinois Formulary For The Drug Product Selection Program (P-3205/94;PF-14820/94;W-289) (E-3778/94) (PR-3204/94;O-14819/94;W-290)
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77 Ill. Adm. Code 1100 Narrative & Planning Policies (P-1799) (E-1941) (P-9357/94;A-2985)
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TYPE OF RULE MAKING

am = amend to existing Section
cc = codification changes
n = New section
r = repeal of existing Section
re = recodified
# = renumbered

ACTION CODE

A = Adopted Rule
E = Emergency
P = Proposed Rule
PP = Peremptory
M = Modification
W = Withdrawl
CC = Codification Changes
RQ = Request for Correction
R = Refusal
PF = Prohibited Filing
S = Suspension
O = JCAR Objection
F = Failure to Remedy Objections Objection
RC = Recommendations
EC = Expedited Correction
C = Correction

TITLE 1

100.100	am	(P-7087;A-13067)

TITLE 2

1226.10	am	(A-1334)
1226.20	am	(A-1334)
1226.110	am	(A-1334)
1226.120	am	(A-1334)
1226.310	am	(A-1334)
1226.330	am	(A-1334)
1226.420	am	(A-1334)
1226.Ap.B	am	(A-1334)

TITLE 8

60.10	am	(P-754)
60.20	am	(P-754)
60.30	am	(P-754)
60.40	am	(P-754)
60.50	am	(P-754)
60.60	am	(P-754)
60.70	am	(P-754)
60.80	r	(P-754)
125.10	am	(PP-1342)
125.100	am	(PP-1342)
125.260	am	(PP-1342)
125.270	am	(PP-1342)
125.380	am	(PP-1342)
255.10	am	(P-1)
255.50	am	(P-1)
255.60	am	(P-1)
255.110	am	(P-1)
255.170	am	(P-1)
256.30	am	(P-13)
256.50	am	(P-13)
256.70	am	(P-13)

TITLE 8 (CONT'D)

600.1	am	(P-2356)
600.300	am	(P-2356)
600.320	am	(P-2356)
600.670	am	(P-2356)
600.Tb.E	am	(P-2356)
1400.146	am	(P-1164)
1400.147	am	(P-1164)

TITLE 11

311.15	n	(P-568)
311.25	n	(P-568)
311.35	n	(P-568)
311.40	am	(P-568)
509.95	am	(P-12043/94; A-2466)
509.150	am	(P-12043/94; A-2466)
1416.50	am	(P-15721/94; A-2471)
1770.10	am	(P-791)
1770.60	am	(P-791)
1770.170	am	(P-791)
1770.190	am	(P-791)
1770.200	am	(P-791)

TITLE 14

130.100	am	(P-2733)
130.135	n	(P-2733)
130.200	am	(P-2733)
130.441	am	(P-2733)
130.538	am	(P-2733)
130.810	am	(P-2733)
130.811	r	(P-2733)
130.820	am	(P-2733)
130.840	am	(P-2733)

TITLE 14 (CONT'D)

165.10	n	(P-14686/94; A-1915)
165.20	n	(P-14686/94; A-1915)
165.30	n	(P-14686/94; A-1915)
165.40	n	(P-14686/94; A-1915)
165.50	n	(P-14686/94; A-1915)
165.60	n	(P-14686/94; A-1915)
165.70	n	(P-14686/94; A-1915)
165.80	n	(P-14686/94; A-1915)
165.90	n	(P-14696/94; A-1915)
550.40	am	(P-14189/94; A-1808)
550.50	am	(P-14189/94; A-1808)
550.60	am	(P-14189/94; A-1808)

TITLE 17

110.4	am	(P-1387)
110.40	am	(P-1387)
110.160	am	(P-1387)
110.180	am	(P-1387)
130.40	am	(P-1378)
130.50	am	(P-1378)
130.60	am	(P-1378)
130.70	am	(P-1378)
130.80	am	(P-1378)
130.100	am	(P-1378)
650.10	am	(P-1414)
650.20	am	(P-1414)
650.21	am	(P-1414)
650.22	am	(P-1414)
650.23	am	(P-1414)
650.40	am	(P-1414)
650.50	am	(P-1414)
650.60	am	(P-1414)

TITLE 17 (CONT'D)

650.65	am	(P-1414)
650.67	n	(P-1414)
650.23	am	(P-1414)
660.10	am	(P-1437)
660.20	am	(P-1437)
660.22	am	(P-1437)
660.25	am	(P-1437)
660.30	am	(P-1437)
660.40	am	(P-1437)
660.50	am	(P-1437)
660.60	am	(P-1437)
670.10	am	(P-1393)
670.20	am	(P-1393)
670.21	am	(P-1393)
670.40	am	(P-1393)
670.50	am	(P-1393)
670.60	am	(P-1393)
710.10	am	(P-16500/94; A-2450)
710.20	am	(P-16500/94; A-2450)
710.25	am	(P-16500/94; A-2450)
710.30	am	(P-16500/94; A-2450)
710.50	am	(P-16500/94; A-2450)
810.37	am	(P-17297/94; A-2396)
810.45	am	(P-17297/94; A-2396)
810.50	am	(P-17297/94; A-2396)
810.70	am	(P-17297/94; A-2396)
1075.10	am	(P-14259/94; A-594)
1075.20	am	(P-14259/94; A-594)
1075.30	am	(P-14259/94; A-594)
1075.40	am	(P-14259/94; A-594)
1075.50	am	(P-14259/94; A-594)
1075.60	am	(P-14259/94; A-594)
1075.80	am	(P-14259/94; A-594)
2520.10	am	(P-3131)
2520.20	am	(P-3131)
2520.30	am	(P-3131)
2520.40	am	(P-3131)
2520.50	am	(P-3131)

TITLE 20

425.10	am	(P-152)
425.12	n	(P-152)
425.15	n	(P-152)
425.20	r	(P-152)
425.30	n	(P-152)
425.40	n	(P-152)
425.50	n	(P-152)
425.60	n	(P-152)
425.70	n	(P-152)
425.80	n	(P-152)
425.90	n	(P-152)
425.100	n	(P-152)
425.110	n	(P-152)
425.120	n	(P-152)

TITLE 23

401.10	n	(P-9756/94; O-2316; PF-2317)
401.20	n	(P-9756/94; O-2316; (PF-2317)
401.30	n	(P-9756/94; O-2316; PF-2317)
401.110	n	(P-9756/94; O-2316; PF-2317)
401.120	n	(P-9756/94; O-2316; PF-2317)

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401.130	n	(P-9756/94; O-2316; PF-2317)
401.140	n	(P-9756/94; O-2316; PF-2317)
401.150	n	(P-9756/94; O-2316; PF-2317)
401.210	n	(P-9756/94; O-2316; PF-2317)
401.220	n	(P-9756/94; O-2316; PF-2317)
401.230	n	(P-9756/94; O-2316; PF-2317)
401.240	n	(P-9756/94; O-2316; PF-2317)
401.250	n	(P-9756/94; O-2316; PF-2317)
401.260	n	(P-9756/94; O-2316; PF-2317)
401.270	n	(P-9756/94; O-2316; PF-2317)
401.280	n	(P-9756/94; O-2316; PF-2317)
1020.10	am	(P-11684/94;A-928)
1020.20	am	(P-11684/94;A-928)
1020.30	am	(P-11684/94;A-928)
1020.40	am	(P-11684/94;A-928)
1020.50	am	(P-11684/94;A-928)
1020.60	am	(P-11684/94;A-928)
1020.70	am	(P-11684/94;A-928)
1020.80	am	(P-11684/94;A-928)
1300.60	am	(E-984)
1501.303	am	(P-13562/94; A-2816)
1501.501	am	(P-12575/94; A-2299)
1501.507	am	(P-12575/94; A-2299)
1501.508	am	(P-13562/94; A-2816)
2700.10	am	(P-883)
2700.20	am	(P-883)
2700.40	am	(P-883)
2700.50	am	(P-883)
2720.6	am	(P-861)
2720.10	am	(P-861)
2720.20	am	(P-861)
2720.25	am	(P-861)
2720.30	am	(P-861)
2720.40	am	(P-861)
2720.41	am	(P-861)
2720.42	am	(P-861)
2720.50	am	(P-861)
2720.55	am	(P-861)
2720.70	am	(P-861)
2720.90	am	(P-861)
2735.20	am	(P-903)
2735.30	am	(P-903)
2735.70	am	(P-903)
2735.80	am	(P-903)
2755.10	n	(P-1288)
2755.20	n	(P-1288)
2755.30	n	(P-1288)
2755.40	n	(P-1288)
2755.50	n	(P-1288)
2755.Ap.A	n	(P-1288)
2760.30	am	(P-920)
2760.Ap.A	n	(P-920)
2760.Ap.B	n	(P-920)
2762.20	am	(P-912)
2762.30	am	(P-912)
2762.40	am	(P-912)

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2763.10	am	(P-894)
2763.20	am	(P-894)
2763.40	am	(P-894)
2763.50	am	(P-894)
2764.10	n	(E-976)
2764.20	n	(E-976)
2764.30	n	(E-976)
2764.40	n	(E-976)
2764.50	n	(E-976)
2765.10	n	(P-1281)
2765.20	n	(P-1281)
2765.30	n	(P-1281)
2765.40	n	(P-1281)
2765.50	n	(P-1281)
2766.10	n	(P-1275)
2766.20	n	(P-1275)
2766.30	n	(P-1275)
2766.40	n	(P-1275)
2771.20	am	(P-852)
2771.30	am	(P-852)
2771.Ap.A	am	(P-852)

TITLE 32

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TITLE 35

219.585	am	(E-3059)
303.322	am	(P-14219/94; A-1310)
307.2400	am	(P-2612)
307.2401	am	(P-2612)
307.2402	am	(P-2612)
307.2403	am	(P-2612)
307.2404	am	(P-2612)
307.2405	am	(P-2612)
307.2406	am	(P-2612)
307.2407	am	(P-2612)
307.2410	n	(P-2612)
307.2490	am	(P-2612)
307.2491	am	(P-2612)
307.6500	am	(P-2612)
307.6501	am	(P-2612)
307.6502	am	(P-2612)
307.6503	am	(P-2612)
372.100	n	(P-4524/94; A-1297)
372.110	n	(P-4524/94; A-1297)
372.200	n	(P-4524/94; A-1297)
372.210	n	(P-4524/94; A-1297)
372.220	n	(P-4524/94; A-1297)
372.230	n	(P-4524/94; A-1297)
372.240	n	(P-4524/94; A-1297)
372.250	n	(P-4524/94; A-1297)
372.300	n	(P-4524/94; A-1297)
372.310	n	(P-4524/94; A-1297)
372.320	n	(P-4524/94; A-1297)
372.400	n	(P-4524/94; A-1297)
372.410	n	(P-4524/94; A-1297)
372.420	n	(P-4524/94; A-1297)
372.430	n	(P-4524/94; A-1297)
372.500	n	(P-4524/94; A-1297)
372.510	n	(P-4524/94; A-1297)
700.106	r	(P-
702.181	am	(P-
703.183	am	(P-
703.201	am	(P-
703.202	am	(P-
703.203	am	(P-
703.213	n	(P-

TITLE 35 (CONT'D)

720.111	am	(P-
720.121	am	(P-
720.130	am	(P-
720.131	am	(P-
721.102	am	(P-
721.103	am	(P-
721.104	am	(P-
721.106	am	(P-
721.Ap.I	am	(P-
.Tb.A	am	(P-
.Tb.B	am	(P-
.Tb.C	am	(P-
.Tb.D	am	(P-
722.122	am	(P-
722.134	am	(P-
723.130	am	(P-
724.101	am	(P-
724.113	am	(P-
724.115	am	(P-
724.156	am	(P-
724.173	am	(P-
724.177	am	(P-
724.279	n	(P-
724.300	n	(P-
724.332	n	(P-
724.701	am	(P-
724.933	am	(P-
724.963	am	(P-
724.980	n	(P-
724.981	n	(P-
724.982	n	(P-
724.983	n	(P-
724.984	n	(P-
724.985	n	(P-
724.986	n	(P-
724.987	n	(P-
724.988	n	(P-
724.989	n	(P-
724.990	n	(P-
724.991	n	(P-
724.1102	am	(P-
725.101	am	(P-
725.113	am	(P-
725.114	am	(P-
725.115	am	(P-
725.117	am	(P-
725.150	am	(P-
725.156	am	(P-
725.171	am	(P-
725.173	am	(P-
725.177	am	(P-
725.192	am	(P-
725.194	am	(P-
725.271	am	(P-
725.272	am	(P-
725.274	am	(P-
725.278	n	(P-
725.301	n	(P-
725.302	am	(P-
725.325	am	(P-
725.331	n	(P-
725.352	am	(P-
725.378	am	(P-
725.477	am	(P-
725.501	am	(P-
725.502	am	(P-
725.503	am	(P-

TITLE 35 (CONT'D)

725.504	am	(P
725.505	am	(P-
725.506	am	(P-
725.933	am	(P-
725.963	am	(P-
725.980	n	(P-
725.981	n	(P-
725.982	n	(P-
725.983	n	(P-
725.984	n	(P-
725.985	n	(P-
725.986	n	(P-
725.987	n	(P-
725.988	n	(P-
725.989	n	(P-
725.990	n	(P-
725.991	n	(P-
725.1102	am	(P-
726.120	am	(P-
726.123	am	(P-
726.200	am	(P-
726.Ap.A	am	(P-
726.Ap.B	am	(P-
726.Ap.C	am	(P-
726.Ap.E	am	(P-
726.Ap.M	n	(P-
728.101	am	(P-
728.102	am	(P-
728.107	am	(P-
728.109	am	(P-
728.130	am	(P-
728.133	am	(P-
728.138	n	(P-
728.140	am	(P-
728.141	am	(P-
728.142	am	(P-
728.143	am	(P-
728.145	am	(P-
728.146	am	(P-
728.148	n	(P-
728.Ap.D	am	(P-
728.Ap.E	am	(P-
728.Ap.J	n	(P-
728.Tb.A	am	(P-
728.Tb.B	am	(P-
728.Tb.C	am	(P-
728.Tb.D	am	(P-
728.Tb.E	am	(P-
728.Tb.G	am	(P-
728.Tb.T	n	(P-
728.Tb.U	n	(P-
730.104	am	(P-
730.105	am	(P-
730.110	am	(P-
730.132	am	(P-
730.133	am	(P-
730.151	am	(P-
738.117	am	(P-
739.110	am	(P-
870.101	am	(P-2144)
870.102	am	(P-2144)
870.201	am	(P-2144)
870.202	am	(P-2144)
870.203	am	(P-2144)
870.204	am	(P-2144)
870.205	am	(P-2144)
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870.211	am	(P-2144)
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870.302	am	(P-2144)
870.303	am	(P-2144)
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870.306	am	(P-2144)
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870.308	am	(P-2144)
870.309	am	(P-2144)
870.310	am	(P-2144)
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871.102	am	(P-2103)
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871.302	am	(P-2103)
871.303	am	(P-2103)
871.304	am	(P-2103)
871.305	am	(P-2103)
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871.403	am	(P-2103)
871.501	am	(P-2103)
871.502	am	(P-2103)
871.503	am	(P-2103)
871.601	am	(P-2103)
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160.90	am	(P-14276/94;A-49)
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200.60	am	(P-2576)
200.70	am	(P-2576)
200.100	am	(P-2576)
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200.270	r	(P-2576)
200.280	r	(P-2576)
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200.310	r	(P-2576)
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950.400	n	(P-2074)
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366.110	n	(P-1452) (E-1921)
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366.502	n	(P-1452) (E-1921)
366.503	n	(P-1452) (E-1921)
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366.601	n	(P-1452) (E-1921)
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610.30	n	(P-15691/94; A-3494)
610.40	n	(P-15691/94; A-3494)
610.50	n	(P-15691/94; A-3494)
610.60	n	(P-15691/94; A-3494)
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240.520	am	(P-2215)
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1255.50	am	(P-2646)
1255.60	am	(P-2646)
1255.70	am	(P-2646)
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285.1104	am	(P-12944/94;A-227)
285.1105	am	(P-12944/94;A-227)
285.1106	am	(P-12944/94;A-227)
285.1107	am	(P-12944/94;A-227)
285.1108	am	(P-12944/94;A-227)
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535.310	am	(P-1745)
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535.330	am	(P-1745)
535.335	am	(P-1745)
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540.80	am	(P-1242)
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594.40	n	(P-8572/94; A-2955)
594.100	n	(P-8572/94; A-2955)
594.110	n	(P-8572/94; A-2955)
594.120	n	(P-8572/94; A-2955)
594.130	n	(P-8572/94; A-2955)
594.140	n	(P-8572/94; A-2955)
594.150	n	(P-8572/94; A-2955)
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594.220	n	(P-8572/94; A-2955)
594.230	n	(P-8572/94; A-2955)
594.240	n	(P-8572/94; A-2955)
594.300	n	(P-8572/94; A-2955)
594.400	n	(P-8572/94; A-2955)
594.410	n	(P-8572/94; A-2955)
594.420	n	(P-8572/94; A-2955)
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672.450	am	(P-14308/94; A-606)
672.505	am	(P-14308/94; A-606)
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672.515	am	(P-14308/94; A-606)
672.520	am	(P-14308/94; A-606)
672.525	r	(P-14308/94; A-606)
672.600	n	(P-14308/94; A-606)
672.605	r	(P-14308/94; A-606)
672.610	am	(P-14308/94; A-606)
672.615	r	(P-14308/94; A-606)
672.620	r	(P-14308/94; A-606)
672.625	r	(P-14308/94; A-606)
672.630	r	(P-14308/94; A-606)
672.635	r	(P-14308/94; A-606)
672.640	r	(P-14308/94; A-606)
672.645	r	(P-14308/94; A-606)
672.650	r	(P-14308/94; A-606)
672.655	r	(P-14308/94; A-606)

TITLE 77 (CONT'D)

672.660	r	(P-14308/94; A-606)
672.665	r	(P-14308/94; A-606)
672.670	r	(P-14308/94; A-606)
693.15	am	(P-8850/94; A-1126)
693.30	am	(P-8850/94; A-1126)
694.20	am	(P-1219)
697.30	am	(P-8840/94; A-1117)
697.200	am	(P-8840/94; A-1117)
697.210	am	(P-8840/94; A-1117)
697.220	am	(P-8840/94; A-1117)
750.110	am	(P-533)
750.120	am	(P-533)
750.140	am	(P-533)
750.160	am	(P-533)
750.180	am	(P-533)
750.185	n	(P-533)
750.186	n	(P-533)
750.187	n	(P-533)
750.189	n	(P-533)
750.240	am	(P-533)
750.250	am	(P-533)
750.310	am	(P-533)
760.110	am	(P-551)
760.120	am	(P-551)
760.150	am	(P-551)
760.190	am	(P-551)
760.195	n	(P-551)
760.196	n	(P-551)
760.197	n	(P-551)
760.199	n	(P-551)
760.230	am	(P-551)
760.240	am	(P-551)
790.10	n	(P-3202/94; PF-14820/94; W-289)(E-3778/94)
790.20	r	(P-3202/94; O-14819/94;W-290)
	n	(P-3205/94; PF-14820/94; W-289)(E-3778/94)
790.40	r	(P-3202/94; O-14819/94;W-290)
	n	(P-3205/94; PF-14820/94; W-289)(E-3778/94)
790.50	n	(P-3205/94; PF-14820/94; W-289)(E-3778/94)
790.60	r	(P-3202/94; O-14819/94;W-290)
	n	(P-3205/94; PF-14820/94; W-289)(E-3778/94)
790.65	n	(P-3205/94; PF-14820/94; W-289)(E-3778/94)
790.80	r	(P-3202/94; O-14819/94;W-290)
	n	(P-3205/94; PF-14820/94; W-289)(E-3778/94)
790.100	r	(P-3202/94; O-14819/94;W-290)
790.120	r	(P-3202/94; O-14819/94;W-290)
790.140	r	(P-3202/94; O-14819/94;W-290)

TITLE 77 (CONT'D)

790.160	r	(P-3202/94; O-14819/94;W-290)
790.180	r	(P-3202/94; O-14819/94;W-290)
790.200	r	(P-3202/94; O-14819/94;W-290)
790.220	r	(P-3202/94; O-14819/94;W-290)
790.240	r	(P-3202/94; O-14819/94;W-290)
790.260	r	(P-3202/94; O-14819/94;W-290)
790.280	r	(P-3202/94; O-14819/94;W-290)
790.300	r	(P-3202/94; O-14819/94;W-290)
790.320	r	(P-3202/94; O-14819/94;W-290)
845.10	am	(P-8021;A-227)
845.12	n	(P-8021;A-227)
845.26	am	(P-8021;A-227)
845.28	am	(P-8021;A-227)
845.29	am	(P-8021;A-227)
845.30	am	(P-8021;A-227)
845.31	n	(P-8021;A-227)
845.32	n	(P-8021;A-227)
845.33	n	(P-8021;A-227)
845.50	am	(P-8021;A-227)
845.Ap.E	am	(P-8021;A-227)
905.10	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.15	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.20	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.30	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.40	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.50	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.55	n	(P-22359/93; O-18405/94;W-287) (P-3299)
905.60	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.70	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.80	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.90	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.100	am	(P-22359/93; O-18405/94;W-287) (P-3299)

TITLE 77 (CONT'D)		
905.110	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.120	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.125	n	(P-22359/93; O-18405/94;W-287) (P-3299)
905.130	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.140	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.150	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.160	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.170	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.180	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.190	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.200	am	(P-22359/93; O-18405/94;W-287) (P-3299)
905.210	r	(P-22359/93; O-18405/94;W-287) (P-3299)
905.Ap.A		
II.A	am	(P-22359/93; O-18405/94;W-287) (P-3299)
II.C	am	(P-22359/93; O-18405/94;W-287) (P-3299)
II.D	am	(P-22359/93; O-18405/94;W-287) (P-3299)
II.E	am	(P-22359/93; O-18405/94;W-287) (P-3299)
II.G	am	(P-22359/93; O-18405/94;W-287) (P-3299)
II.H	am	(P-22359/93; O-18405/94;W-287) (P-3299)
II.I	am	(P-22359/93; O-18405/94;W-287)
Ex.A	am	(P-3299)
Ex.C	am	(P-3299)

TITLE 77 (CONT'D)		
Ex.D	am	(P-3299)
II.J	am	(P-22359/93; O-18405/94;W-287)
Ex.A	am	(P-3299)
Ex.B	am	(P-3299)
Ex.C	am	(P-3299)
Ex.D	am	(P-3299)
II.K	am	(P-22359/93; O-18405/94;W-287)
Ex.A	am	(P-3299)
Ex.B	am	(P-3299)
Ex.C	am	(P-3299)
Ex.D	am	(P-3299)
Ex.E	am	(P-3299)
Ex.F	am	(P-3299)
Ex.G	am	(P-3299)
Ex.H	am	(P-3299)
II.L	am	(P-22359/93, O-18405/94;W-287)
		(3299)
Ex.A	am	(P-3299)
Ex.B	am	(P-3299)
Ex.C	am	(P-3299)
II.M	am	(P-22359/93; O-18405/94;W-287) (P-3299)
Ex.A	r	(P-22359/93; O-18405/94;W-287) (P-3299)
Ex.A	n	(P-3299)
Ex.B	r	(P-22359/93; O-18405/94;W-287)
Ex.B	n	(P-3299)
II.N	am	(P-22359/93; O-18405/94;W-287) (P-3299)
Ex. A	am	(P-3299)
Ex. B	am	(P-3299)
Ex. C	am	(P-3299)
II. O	am	(P-3299)
Ex. A	am	(P-3299)
Ex. B	am	(P-3299)
II. P	am	(P-3299)
II.Q	am	(P-3299)
II.R	am	(P-22359/93; O-18405/94;W-287) (P-3299)
Ex. A	am	(P-3299)
Ex. B	am	(P-3299)
Ex. C	n	(P-3299)
II. S	am	(P-3299)
Ex.A	am	(P-3299)
Ex.B	am	(P-3299)
II.T	am	(P-3299)
II.U	am	(P-22359/93; O-18405/94;W-287) (P-3299)
Ex.A	am	(P-3299)
Ex.B	am	(P-3299)
II. V	am	(P-3299)
Ex. A	am	(P-3299)
Ex. B	am	(P-3299)
Ex. C	n	(P-3299)
II. W	am	(P-3299)
II. X	n	(P-3299)
980.10	n	(P-1224)
980.20	n	(P-1224)

TITLE 77 (CONT'D)		
980.30	n	(P-1224)
980.40	n	(P-1224)
980.50	n	(P-1224)
980.60	n	(P-1224)
980.70	n	(P-1224)
980.80	n	(P-1224)
980.90	n	(P-1224)
980.100	n	(P-1224)
980.110	n	(P-1224)
980.120	n	(P-1224)
990.10	n	(P-1234)
990.20	n	(P-1234)
990.30	n	(P-1234)
990.40	n	(P-1234)
990.50	n	(P-1234)
990.60	n	(P-1234)
990.70	n	(P-1234)
990.80	n	(P-1234)
990.90	n	(P-1234)
990.100	n	(P-1234)
990.110	n	(P-1234)
990.120	n	(P-1234)
990.100	n	(P-1234)
990.110	n	(P-1234)
990.120	n	(P-1234)
1100.740	am	(P-1799) (E-1941)
1100.750	n	(P-9357/94; A-2985)
1110.2610	n	(P-9364/94; A-2991)
1110.2620	n	(P-9364/94; A-2991)
1110.2630	n	(P-9364/94; A-2991)
1110.2640	n	(P-9364/94; A-2991)
1110.2650	n	(P-9364/94; A-2991)
1130.140	am	(P-8867/94; A-2972) O-17288/94; R-3088; A-2972)
1130.210	am	(P-8867/94; A-2972)
1130.310	am	(P-8867/94; A-2972)
1130.410	am	(P-8867/94; A-2972)
1130.520	am	(P-8867/94; A-2972)
1130.530	r	(P-8867/94; A-2972)
1130.570	am	(P-8867/94; A-2972)
1130.620	am	(P-8867/94; A-2972)
1130.650	am	(P-8867/94; A-2972)
1130.710	am	(P-8867/94; A-2972)
1130.720	am	(P-8867/94; A-2972)
1130.730	am	(P-8867/94; A-2972)
1130.740	am	(P-8867/94; A-2972)
1130.750	am	(P-8867/94; A-2972)
1130.760	am	(P-8867/94; A-2972)
1130.770	am	(P-8867/94; A-2972)
1130.780	am	(P-8867/94; A-2972)
1130.790	n	(P-8867/94; A-2972)
1130.Ap.A	am	(P-8861/94; A-2972)
2090.20	am	(P-3106)
2090.35	am	(P-1156)
2090.40	am	(P-3106)
2090.70	am	(P-3106)
2090.90	am	(P-1156)
2090.100	am	(P-1156)
2090.110	am	(P-1156)
2510.30	am	(P-2189)
2510.40	am	(P-2189)
2510.70	am	(P-14533/94; A-1825)
2510.85	n	(P-2189)
TITLE 80		
100.5	n	(P-12585/94;A-206)

TITLE 80 (CONT'D)		
100.10	am	(P-12585/94;A-206)
100.20	am	(P-12585/94;A-206)
100.30	am	(P-12585/94;A-206)
100.40	am	(P-12585/94;A-206)
100.50	am	(P-12585/94;A-206)
100.55	am	(P-12585/94;A-206)
100.60	n	(P-12585/94;A-206)
100.70	am	(P-12585/94;A-206)
100.80	am	(P-12585/94;A-206)
100.90	am	(P-12585/94;A-206)
100.100	am	(P-12585/94;A-206)
100.110	am	(P-12585/94;A-206)
100.115	n	(P-12585/94;A-206)
100.117	n	(P-12585/94;A-206)
100.120	am	(P-12585/94;A-206)
100.130	am	(P-12585/94;A-206)
100.140	am	(P-12585/94;A-206)
100.150	am	(P-12585/94;A-206)
150.430	am	(P-1270)
302.30	am	(P-2539)
302.300	am	(P-2539)
302.785	am	(P-2539)
303.90	am	(P-2524)
303.125	am	(P-2524)
303.130	n	(P-2524)
303.140	am	(P-2524)
303.145	am	(P-2524)
303.148	am	(P-2524)
303.155	am	(P-2524)
303.390	n	(P-2524)
310.230	am	(P-2365) (P-3122)
	am	(P-16490/94; A-3456)
310.270	am	(PP-2481)
310.290	am	(P-14256/94; A-1024) (P-2365)
310.450	am	(P-14256/94; A-1024)
310.490	am	(P-14256/94; A-1024)
310.530	am	(P-14256/94; A-1024)
310.540	am	(P-14256/94; A-1024)
310.Ap.A	r	(P-764)
	n	(P-764)
.Tb.A	am	(PP-2481)
.Tb.B	am	(PP-2481)
.Tb.G	am	(PP-3073)
.Tb.H	am	(PP-2481)
.Tb.I	am	(PP-2481)
.Tb.L	r	(P-764)
	n	(P-764)
.Tb.T	am	(PP-2481)
.Tb.U	am	(PP-3073)
310.Ap.C	am	(P-14256/94; A-1024)
310.Ap.D	am	(P-14256/94; A-1024)
310.Ap.G	am	(P-14256/94; A-1024)
2110.440	am	(P-774)
2120.440	am	(P-779)
2800.100	am	(P-12567/94;A-36)
2800.230	am	(P-12567/94;A-36)
2800.235	n	(P-12567/94;A-36)

TITLE 80 CONT'D)		
2800.240	am	(P-12567/94;A-36)
2800.260	am	(P-12567/94;A-36)
2800.600	am	(P-12567/94;A-36)
2800.700	am	(P-12567/94;A-36)
2800.Ap.A	n	(P-2098)
3000.Ap.A	am	(P-2093)
TITLE 83		
410.410	n	(P-14521/94; A-2804)
410.420	n	(P-14521/94; A-2804)
410.430	n	(P-14521/94; A-2804)
410.440	n	(P-14521/94; A-2804)
410.450	n	(P-14521/94; A-2804)
410.460	n	(P-14521/94; A-2804)
410.470	n	(P-14521/94; A-2804)
410.480	n	(P-14521/94; A-2804)
410.490	n	(P-14521/94; A-2804)
410.Tb.A	n	(P-14521/94; A-2804)
TITLE 86		
100.2100	am	(P-15546/94; A-1839)
100.2101	n	(P-15546/94; A-1839)
100.2110	n	(P-15546/94; A-1839)
100.2120	n	(P-15388/94; A-1839)
100.2130	n	(P-15388/94; A-1839)
100.2140	n	(P-15388/94; A-1839)
100.2160	n	(P-15388/94; A-1839)
100.2170	n	(P-15388/94; A-1839)
100.2180	n	(P-15388/94; A-1839)
100.2590	n	(P-14346/94; A-1839)
100.3120	am	(P-14346/94; A-1839)
100.7010	am	(P-14346/94; A-1839)
100.7200	am	(P-14878/94; A-1839)
100.7300	am	(P-14878/94; A-1839)
105.515	n	(P-1022) (E-1139)
110.190	am	(P-3454) (E-3555)
110.192	n	(P-3454) (E-3555)
110.195	n	(P-2394) (E-2476)
130.331	n	(P-571)
500.100	n	(P-14634/94; A-3008)
500.101	r	(P-14634/94; A-3008)
500.102	r	(P-14634/94; A-3008)
500.200	am	(P-14634/94; A-3008)
500.201	n	(P-14634/94; A-3008)
500.202	am	(P-14634/94; A-3008)
500.203	am	(P-14634/94; A-3008)
500.204	am	(P-14634/94; A-3008)
500.205	am	(P-14634/94; A-3008)
500.210	n	(P-14634/94; A-3008)
500.215	n	(P-14634/94; A-3008)
500.220	r	(P-14634/94; A-3008)
500.225	r	(P-14634/94; A-3008)
500.230	am	(P-14634/94; A-3008)
500.235	am	(P-14634/94; A-3008)
500.250	r	(P-14634/94; A-3008)
500.260	am	(P-14634/94; A-3008)
500.265	am	(P-14634/94; A-3008)
500.270	am	(P-14634/94; A-3008)
500.275	am	(P-14634/94; A-3008)
500.280	am	(P-14634/94; A-3008)
500.285	am	(P-14634/94; A-3008)
500.290	r	(P-14634/94; A-3008)
500.295	r	(P-14634/94; A-3008)
500.300	n	(P-14634/94; A-3008)
500.301	r	(P-14634/94; A-3008)
500.302	r	(P-14634/94; A-3008)
500.305	n	(P-14634/94; A-3008)

TITLE 86 (CONT'D)		
500.310	n	(P-14634/94; A-3008)
500.315	n	(P-14634/94; A-3008)
500.320	n	(P-14634/94; A-3008)
500.325	n	(P-14634/94; A-3008)
500.330	n	(P-14634/94; A-3008)
500.335	n	(P-14634/94; A-3008)
500.340	n	(P-14634/94; A-3008)
500.345	n	(P-14634/94; A-3008)
500.350	n	(P-14634/94; A-3008)
500.355	n	(P-14634/94; A-3008)
500.360	n	(P-14634/94; A-3008)
500.400	am	(P-14634/94; A-3008)
500.405	n	(P-14634/94; A-3008)
500.500	am	(P-14634/94; A-3008)
500.501	r	(P-14634/94; A-3008)
500.505	am	(P-14634/94; A-3008)
500.600	am	(P-14634/94; A-3008)
700.300	am	(P-9394/94; A-1909)
750.300	am	(P-2389)
750.400	am	(P-2389)
800.1000	n	(P-2385)
800.4000	n	(P-2385)
TITLE 89		
102.25	am	(P-13723/94; A-1108) (P-14622/94; A-1108)
104.103	am	(P-14872/94; A-1321)
104.208	am	(P-14615/94; A-1321)
104.209	n	(P-12613/94; A-1321)
104.210	am	(P-12613/94; A-1321)
104.211	n	(P-14613/94; A-1321)
104.221	am	(P-12613/94; A-1321)
104.244	am	(P-12613/94; A-1321)
111.101	am	(P-15707/94; A-2886)
112.70	am	(P-11461/94; A-2845)
112.78	am	(P-11461/94; A-2845)
112.82	am	(P-7208/94; A-15774/94; RQ-18407/94; EC-998)
112.148	am	(P-804)
112.300	am	(P-804)
112.306	am	(P-804)
113.113	am	(P-14281/94; A-1052)
113.130	am	(P-14590; A-2875)
113.141	am	(P-14281/94; A-1052)
113.155	r	(P-14590/94; A-2875)
113.157	am	(P-14281/94; A-1052)
113.248	am	(P-14281/94; A-1052)
113.253	am	(P-815)
113.260	am	(P-815)
116.400	am	(P-824)
116.510	am	(P-824)
117.15	am	(P-14303/94; A-1103)
117.80	am	(P-3295)
118.300	am	(P-829)
120.246	am	(P-14830/94; A-2905)
120.347	n	(P-14830/94; A-2905)
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